

1958

Some Non-Religious Views against Proposed Mercy-Killing Legislation

Yale Kamisar

Follow this and additional works at: <https://scholarship.law.umn.edu/mlr>



Part of the [Law Commons](#)

Recommended Citation

Kamisar, Yale, "Some Non-Religious Views against Proposed Mercy-Killing Legislation" (1958). *Minnesota Law Review*. 2588.
<https://scholarship.law.umn.edu/mlr/2588>

This Article is brought to you for free and open access by the University of Minnesota Law School. It has been accepted for inclusion in Minnesota Law Review collection by an authorized administrator of the Scholarship Repository. For more information, please contact lenzx009@umn.edu.

MINNESOTA LAW REVIEW

Volume 42

May, 1958

No. 6

SOME NON-RELIGIOUS VIEWS AGAINST PROPOSED "MERCY-KILLING" LEGISLATION

YALE KAMISAR*

*At the Crystal Palace Aquarium not long
ago I saw a crab euthanatising a sickly fish,
doubtless from the highest motives.¹*

A recent book, Glanville Williams' *The Sanctity of Life and the Criminal Law*,² once again brings to the fore the controversial topic of euthanasia,³ more popularly known as "mercy killing". In keeping with the trend of the euthanasia movement over the past generation, Williams concentrates his efforts for reform on the *voluntary* type of euthanasia, for example, the cancer victim begging for death; as opposed to the *involuntary variety*, that is, the case of the congenital idiot, the permanently insane or the senile.

*Associate Professor of Law, University of Minnesota Law School. This paper was aided by a research grant from the Graduate School of the University of Minnesota. The author acknowledges the constructive criticism of Professor Kenneth Culp Davis of the University of Minnesota Law School and the valuable assistance of Dr. Eugene Bernstein, Fellow, University of Minnesota Medical School.

1. Anonymous letter to the editor, 46 *The Spectator* 241 (1873).

2. (1957) (This book is hereinafter referred to as "Williams").

The book is an expanded and revised version of the James S. Carpentier lectures delivered by Professor Williams at Columbia University and at the Association of the Bar of the City of New York in the Spring of 1956. "The connecting thread," observes the author, "is the extent to which human life, actual or potential, is or ought to be protected under the criminal law of the English-speaking peoples," Preface, p. vii. The product of his dexterous needlework, one might add, is a coat of many colors: philosophical, medical, ethical, religious, social, as well as legal. *The Un-Sanctity of Life* would seem to be a more descriptive title, however, since the author presents cogent reasons for de-criminalizing infanticide and abortion at one end of man's span, and "unselfish abetment of suicide and the unselfish homicide upon request," *id.* at 310, at the other.

The book was recently lauded by Bertrand Russell, 10 *Stan. L. Rev.* 382 (1958). For more restrained receptions see the interesting and incisive reviews by Professor William J. Curran, 71 *Harv. L. Rev.* 585 (1958) and Professor Richard C. Donnelly, 67 *Yale L.J.* 753 (1958).

3. Euthanasia has a Greek origin: *eu* (easy, happy, painless), *thanatos* (death). The term apparently first appeared in the English language in the early seventeenth century in its original meaning—a gentle, easy death. The term then came to mean the *doctrine* or *theory* that in certain circumstances a person should be painlessly killed, and, more recently has come to mean the *act* or *practice* of bringing about a gentle and easy death. In its broad sense, euthanasia embraces a variety of situations, some where the patient is capable of consenting to his death, others where he obviously is not. Thus,

When a legal scholar of Williams' stature⁴ joins the ranks of such formidable criminal law thinkers as America's Herbert Wechsler and the late Jerome Michael,⁵ and England's Hermann Mannheim⁶ in approving voluntary euthanasia, at least under certain circumstances, a major exploration of the bases for the euthanasia prohibition seems in order.⁷ This need is underscored by the fact that Williams' book arrives on the scene so soon after the stir caused by a brilliant Anglican clergyman's plea for voluntary euthanasia.⁸

The Law On The Books condemns all mercy-killings.⁹ That this

two generations ago, H. J. Rose defined the euthanasia circumstances as "when owing to disease, senility, or the like, a person's life has ceased to be either agreeable or useful". 7 Encyclopedia of Religion and Ethics 598 (Hastings ed. 1912). In the 1930's there sprung up organizations in both England and America which dramatized the plight of the patient in "unnecessary" pain and urged euthanasia for the incurable and suffering patient who wanted to die. Consequently, a current popular meaning of the term is painless death "releasing" the patient from severe physical suffering. An advocate of euthanasia has been called a "euthanasiast"; to subject to euthanasia has been called to "euthanatize." These terms will be so used throughout this paper. See generally Fletcher, *Morals and Medicine* 172-73 (1954) Sullivan, *The Morality of Mercy Killing* 1-3 (1950) (originally a dissertation entitled *Catholic Teaching on the Morality of Euthanasia*); Banks, *Euthanasia*, 161 Practitioner 101 (1948).

4. Williams' admirable treatise, *Criminal Law: The General Part* (1953), stamps him as one of the giants in the field.

5. Wechsler and Michael, *A Rationale of the Law of Homicide: I*, 37 Colum. L. Rev. 701, 739-40 (1937). Since the article was written before the Nazi euthanasia venture, it is conceivable that Prof. Wechsler, who had ample opportunity to study the Nazi experience as Technical Adviser to American Judges, International Military Tribunal, would come out somewhat differently today.

6. Mannheim, *Criminal Justice and Social Reconstruction* 13-17 (1946).

7. Since the proposals for reform which have commanded the greatest attention have urged complete immunization of voluntary euthanasia, this paper is concerned with whether or not such killings should be legalized, not whether or not they should be regarded as murder, which is now the case, see note 9 *infra*, or some lesser degree of criminal homicide. One way to achieve mitigation would be to give recognition to "good motive" generally; another would be to make a specific statutory reduction of penalty for voluntary euthanasia alone. For a discussion of these alternatives, see Kalven, *A Special Corner of Civil Liberties: A Legal View I*, 31 N.Y.U.L. Rev. 1223, 1235-36 (1956); Silving, *Euthanasia: A Study In Comparative Criminal Law*, 103 U. of Pa. L. Rev. 350, 386-89 (1954). The Royal Commission on Capital Punishment (1949-53) took the position that "mercy killings" could not feasibly be reduced in penalty. See text at note 34 and note 34 *infra*.

8. Fletcher, *op. cit. supra*, note 3 at 172-210 (1954). The book is quite similar to Williams in that it deals with the moral and legal issues raised by contraception, artificial insemination, sterilization and right of the patient to know the truth. It is the subject of an interesting and stimulating symposium review, 31 N.Y.U.L. Rev. 1160-1245 (1956) by two lawyers, Prof. Harry Kalven and Judge Morris Ploscowe; two theologians, Emanuel Rackman and Paul Ramsey; two philosophers, Horace M. Kallen and Joseph D. Hasset; and a physician, I. Phillips Frohman.

9. In Anglo-American jurisprudence a "mercy-killing" is murder. In theory, neither good motive nor consent of the victim is relevant. See, *e.g.*, 2 Burdick, *Law of Crimes* §§ 422, 447 (1946); Miller, *Criminal Law* 55,

has a substantial deterrent effect, even its harshest critics admit.¹⁰ Of course, it does not stamp out all mercy-killings, just as murder and rape provisions do not stamp out all murder and rape, but presumably it does impose a substantially greater responsibility on physicians and relatives in a euthanasia situation and turns them away from significantly more doubtful cases than would otherwise be the practice under any proposed euthanasia legislation to date. When a mercy-killing occurs, however, *The Law In Action* is as malleable as *The Law On The Books* is uncompromising. The high incidence of failures to indict,¹¹ acquittals,¹² suspended sentences¹³ and reprieves¹⁴ lend considerable support to the view that—

If the circumstances are so compelling that the defendant ought to violate the law, then they are compelling enough for the jury to violate their oaths. The law does well to declare these homicides unlawful. It does equally well to put no more than the sanction of an oath in the way of an acquittal.¹⁵

The complaint has been registered that "the prospect of a sentimental acquittal cannot be reckoned as a certainty."¹⁶ Of course not. The defendant is not always *entitled* to a sentimental acquittal. The few American convictions cited for the proposition that the present state of affairs breeds "inequality" in application may be cited as well for the proposition that it is characterized by

172 (1934); Perkins, *Criminal Law* 721 (1957); 1 Wharton, *Criminal Law and Procedure* § 194 (Anderson 1957); Orth, *Legal Aspects Relating to Euthanasia*, 2 Md. Med. J. 120 (1953) (symposium on euthanasia); 48 Mich. L. Rev. 1199 (1950); Anno., 25 A.L.R. 1007 (1923).

In a number of countries, e.g., Germany, Norway, Switzerland, a compassionate motive and/or "homicide upon request" operate to reduce the penalty. See generally Helen Silving's valuable comparative study, *supra* note 7. However, apparently only Uruguayan law completely immunizes a homicide characterized by both of the above factors. *Id.* at 369 and n. 74. The Silving article only contains an interesting and fairly extensive comparative study of assisted suicide and the degree to which it is treated differently from a direct "mercy-killing." In this regard see also Friedman, *Suicide, Euthanasia and the Law*, 85 Med. Times 681 (1957).

10. See Williams, p. 342.

11. See, e.g., the case of Harry C. Johnson, who asphyxiated his cancer-stricken wife, apparently at her urging. N.Y. Times, Oct. 2, 1938, p. 1, col. 3; Oct. 3, 1938, p. 34, col. 3. Various psychiatrists reported that Johnson was "temporarily insane" at the time of the killing, but was "now sane", N.Y. Times, Oct. 12, 1938, p. 30, col. 4. A week later, a Nassau County grand jury refused to indict him. N.Y. Times, Oct. 19, 1938, p. 46, col. 1.

12. See, e.g., the *Sander, Paigh* and *Braunsdorf* cases discussed at notes 172-176, 183, *infra*.

13. See e.g., the *Repouille* case discussed at note 181, *infra*.

14. See e.g., the *Brownhill* and *Long* cases discussed at notes 178-179, *infra*.

15. Curtis, *It's Your Law* 95 (1954).

16. Williams, p. 328.

elasticity and flexibility.¹⁷ In any event, if inequality of application suffices to damn a particular provision of the criminal law, we might as well tear up all our codes—beginning with the section on chicken-stealing.¹⁸

17. Both Williams, at 328, and Prof. Harry Kalven, *supra* note 7 at 1235, cite a single authority for the proposition that the prevailing system does not afford equality of treatment of mercy killers. That single authority is Helen Silving's study, *supra* note 7. Silving in turn relies on a single case, that of Harold Mohr, who was convicted of voluntary manslaughter and sentenced to from three to six years in prison, for the slaying of his blind, cancer-stricken brother. Unlike other mercy killing cases which resulted in acquittals, Mohr's victim had apparently made urgent and repeated requests for death. *Id.* at 354 and n. 15. Silving fails to note however, that Mohr's defense that he "blackened out" just before the shooting was likely to be received with something less than maximum sympathy in light of the fact, pressed hard by the prosecution, that immediately prior to shooting his brother he made a round of taprooms and clubs for seven hours and consumed ten to twelve beers in the process. N.Y. Times, April 8, 1950, p. 26, col. 1. Nor was the jury likely to consider it insignificant that two other brothers of Mohr testified on behalf of the state. *Ibid.* So far as I know, this is the only mercy killing case where relatives testified against the defendant.

In *Repouille v. United States*, 165 F. 2d 152, 153 (2d cir. 1947) (denying citizenship to alien on ground that chloroforming of idiot son impaired "good moral character"), Judge Learned Hand noted that while Repouille had received a suspended sentence, a "similar offender in Massachusetts" had been imprisoned for life. This, evidently, is a reference to the case of John F. Noxon, who, less than two years after Repouille's mercy-killing, was sentenced to death for electrocuting his idiot son. The sentence was then commuted to life. See note 182, *infra*. But Noxon banked all on the defense that the electrocution had been just an accident, a gamble entailing the risk that the jury would be quite unsympathetic to him if it disbelieved his story. Certainly, a full presentation of the appealing "mercy killing" circumstances would be more difficult under the theory Noxon adopted than under the typical "temporary insanity" defense. That different legal tactics lead to "inequality of treatment" on similar facts is obvious.

Furthermore, the jury might well have been revolted by the manner in which the act was perpetrated: electrocuting the infant by wrapping wire around him, dressing him in wet diapers, and placing him on a silver serving tray. Then, too, whereas Repouille's son was a thirteen-year-old with the mentality of a two-year-old and Greenfield's son, to draw upon another leading case of this type, see note 180, *infra*, was a seventeen-year-old with the mentality of a two-year-old, Noxon's son was only a six-month infant who apparently *would never develop* the mentality of an adult—a situation the jury might well view as less pathetic, at least less provoking. Finally, it should be noted that even in the *Noxon* case, the Law In Action was not without effect. His death sentence was commuted to life and, a year after Judge Hand's apparent reference to him, further commuted to six years. He was paroled less than five years after his conviction of first degree murder. See note 182, *infra*.

In any event, the legislation urged by Williams, Fletcher and the English and American euthanasia societies would in no way relieve the plight of a "mercy-killer" such as Noxon, for his was an act of *involuntary* euthanasia and hence beyond the scope of present proposals.

18. "Not a great many years ago, upon the Norfolk circuit, a larceny was committed by two men in a poultry yard, but only one of them was apprehended; the other having escaped into a distant part of the country, had eluded all pursuit. At the next assizes the apprehended thief was tried and convicted; but Lord Loughborough, before whom he was tried, thinking the offence a very slight one, sentenced him only to a few months imprisonment. The news of this sentence having reached the accomplice in his retreat,

The criticism is also made that "public confidence in the administration of criminal justice is hardly strengthened when moral issues are shifted instead of being solved, or when the law relegates to juries the function of correcting its inequities."¹⁹ But there are many, many occasions on which the jury wrestles with moral issues, and there is certainly substantial support for this practice.²⁰

he immediately returned, and surrendered himself to take his trial at the next assizes. The next assizes came; but, unfortunately for the prisoner, it was a different judge who presided; and still more unfortunately, Mr. Justice Gould, who happened to be the judge, though of a very mild and indulgent disposition, had observed, or thought he had observed, that men who set out with stealing fowls, generally end by committing the most atrocious crimes; and building a sort of system upon this observation, had made it a rule to punish this offence with very great severity, and he accordingly, to the great astonishment of this unhappy man, sentenced him to be transported. While one was taking his departure for Botany Bay, the term of the other's imprisonment had expired; and what must have been the notions which that little public, who witnessed and compared these two examples, formed of our system of criminal jurisprudence?"

Romilly, Observations on the Criminal Law of England 18-19 (1810). The observations constitute a somewhat revised and expanded version of a famous speech delivered in the House of Commons in support of bills to repeal legislation making it a capital offence to commit certain petty thefts. A substantial portion of the speech, including the extract above, is reprinted in Michael and Wechsler, *Criminal Law and its Administration* 252-55 (1940). For recent instances of disparities and erraticism in sentencing, see Glueck, *The Sentencing Problem*, Fed. Prob., Dec. 1956, p. 15.

19. Silving, *supra* note 7, at 354.

20. For example, in the famous case of *Durham v. United States*, 214 F. 2d 862 (D.C. Cir. 1954) regarded by many as a triumph over the forces of darkness in the much-agitated area of mental responsibility, the Court concluded (214 F. 2d at 876):

Finally, in leaving the determination of the ultimate question of fact to the jury, we permit it to perform its traditional function which . . . is to apply 'our inherited ideas of moral responsibility to individuals prosecuted for crime. . . .' Juries will continue to make moral judgments, still operating under the fundamental precept that 'our collective conscience does not allow punishment where it cannot impose blame.'

To take another example, the difficult area of criminal law dealing with causal relationship between conduct and result, "as has often been said, the question usually presented is not whether there is cause in fact, but rather whether there should be liability for results in fact caused." Wechsler and Michael, *supra* note 5, at 724. Herbert Wechsler, the Chief Reporter of the Model Penal Code, favors the "culpability" rather than "causality" approach, 32 ALI proceedings 162-63 (1955), and this view may very well be ultimately adopted. See section 2.03 (2) (b) of the Model Penal Code (Tent. Draft No. 4, 1955) and the appropriate comment to this section, *id.* at 135, for a discussion of the advantages and disadvantages "of putting the issue squarely to the jury's sense of justice." To take still another example, the elusive distinction between first and second degree murder has well been described as "merely a privilege offered to the jury to find the lesser degree when the suddenness of the intent, the vehemence of the passion, seems to call irresistibly for the exercise of mercy." Cardozo, *What Medicine Can Do For Law*, in *Law and Literature* 100 (1931). This view is buttressed by the subsequent disclosure that of some 700 cases, every homicide case contained in the New York reports at that time, "only three cases have been found where on a murder charge, the indictment was for second degree murder." New York Revision Commission, *Communication and Study Relating to Homicide* 82 n. 202 (1937). Cardozo pointed out that he had "no objection

The existing law on euthanasia is hardly perfect. But if it is not too good, neither, as I have suggested, is it much worse than the rest of the criminal law. At any rate, the imperfections of the existing law are not cured by Williams' proposal. Indeed, I believe adoption of his views would add more difficulties than it would remove.

Williams strongly suggests that "euthanasia can be condemned only according to a religious opinion."²¹ He tends to view the opposing camps as Roman Catholics versus Liberals. Although this has a certain initial appeal to me, a non-Catholic and a self-styled liberal, I deny that this is the only way the battle lines can, or should, be drawn. I leave the religious arguments to the theologians. I share the view that "those who hold the faith may follow its precepts without requiring those who do not hold it to act as if they did."²² But I do find substantial utilitarian obstacles on the high road to euthanasia.²³

to giving them [the jury] this dispensing power, but it should be given to them directly and not in a mystifying cloud of words." From the frequency with which the dispensing power is exercised, and the manner in which it is viewed by the press and public generally, it seems fairly clear that nobody is mystified very much in the mercy-killing cases.

21. Williams, p. 312. This seems to be the position taken by Bertrand Russell in his review of Williams' book (*supra* note 2 at 382):

The central theme of the book is the conflict in the criminal law between the two divergent systems of ethics which may be called respectively utilitarian and taboo morality. . . . Utilitarian morality in the wide sense in which I am using the word, judges actions by their effects. . . . In taboo morality . . . forbidden actions are sin, and they do not cease to be so when their consequences are such as we should all welcome.

I trust Russell would agree, if he should read this paper, that the issue is not quite so simple. At any rate, I trust he would agree that I stay within the system of utilitarian ethics.

22. Wechsler and Michael, *supra* note 5 at 740. But see Denning, *The Influence of Religion*, in *The Changing Law* 99 (1953) ("without religion there can be no morality; and without morality there can be no law"). Lord Justice Denning's assertion is the motif of Fitch, Harding, Katz and Quillian, *Religion, Morality and Law* (1956).

23. I am aware that the arguments I set forth, however "reasonable" or "logical" some of them may be, were not the reasons which first led to the prohibition against mercy-killings. I realize, too, that those who are inexorably opposed to any form of euthanasia on religious grounds do not always limit their arguments to religious ones. See, e.g., Martin, *Euthanasia and Modern Morality*, 10 *The Jurist* 437 (1950) which views the issue as a conflict between Christianity and paganism, and, in addition raises many non-religious objections. I risk, therefore, the charge that I am but another example of "the tendency of the human mind to graft upon an actual course of conduct a justification or even a duty to observe this same course in the future." Stone, *The Province and Function of Law* 673-74 (1946). I would meet this charge with the observation that "ordinary experience seems to indicate quite clearly that the reasons people give for their religious, political, economic and legal policies do influence the development of these policies, and that the 'good reasons' professed by our fathers yesterday are among the real reasons of the life of today" M. R. Cohen, *The Faith of a Liberal* 70 (1946).

After all, that the criminal law itself arose to fill the need to regulate

As an ultimate philosophical proposition, the case for voluntary euthanasia is strong. Whatever may be said for and against suicide generally,²⁴ the appeal of death is immeasurably greater when it is sought not for a poor reason or just any reason, but for "good cause," so to speak; when it is invoked not on behalf of a "socially useful" person, but on behalf of, for example, the pain-racked "hopelessly incurable" cancer victim. If a person is *in fact* (1) presently incurable, (2) beyond the aid of any respite which may come along in his life expectancy, suffering (3) intolerable and (4) unmitigable pain and of a (5) fixed and (6) rational desire to die, I would hate to have to argue that the hand of death should be stayed. But abstract propositions and carefully formed hypotheticals are one thing; specific proposals designed to cover everyday situations are something else again.

In essence, Williams' specific proposal is that death be authorized for a person in the above situation "by giving the medical

and obviate self-help and private vengeance, see, *e.g.*, 2 Holdsworth, *History of English Law* 43-47 (4th ed. 1936); Holmes, *The Common Law* 2-3, 40 (1881); Maine, *Ancient Law* 391-401 (Pollock ed. 1930); to say nothing of a possible point of origin in "a religious institution of sacrificing an impious wrongdoer to an offending god who might else inflict his wrath upon the whole community," Pound, *Criminal Justice in America* 54 (1930), renders deterrence, incapacitation and rehabilitation no less the "real reasons" of today and no less the real bases for drafting new codes or amending old ones.

I would meet the charge, too, by pointing out that I am not enamored of the status quo on mercy-killing. But while I am not prepared to defend it against all comers, I am prepared to defend it against the proposals for change which have come forth to date.

24. Unlike Professor Williams, even many proponents of voluntary euthanasia appear to shrink from suicide as a general proposition. Consider, for example, the following statements made by vice-presidents of England's Voluntary Euthanasia Legalisation Society:

The act of the suicide is wrong because he takes his own life solely on his own judgment. It may be that he does so in a mood of despair or remorse and thus evades the responsibility of doing what he can to repair the wrong or improve the situation. He flings away his life when there is still the possibility of service and when there are still duties to be done. The proposals for Voluntary Euthanasia have nothing in common with suicide. They take the decision out of the hands of the individual. The case is submitted to the objective judgment of doctors and specially appointed officials whose duty it would be to enquire whether the conditions which constitute the sinfulness of suicide are present or not.

Matthews, *Voluntary Euthanasia: The Ethical Aspects* 4-5 (Address by the Very Rev. W. R. Matthews, Dean of St. Paul's, Voluntary Euthanasia Legalisation Society Annual Meeting, May 2, 1950) (distributed by the American and English Societies).

[I]n respect of each of its citizens, the State has made an investment of a substantial amount, and as a mere matter of business it is entitled to demand an adequate return. If a useful citizen, by taking his life, diminishes that return, he does an anti-social act to the detriment of the community as a whole. We cannot carry the doctrine of isolation to the extent of saying that we live unto ourselves. Hence it appears on purely rationalistic grounds that the State is entitled to discountenance suicide.

Earengy, *Voluntary Euthanasia*, 8 *Medico-Legal Rev.* 91, 92 (1940).

practitioner a wide discretion and trusting to his good sense."²⁵ This, I submit, raises too great a risk of abuse and mistake to warrant a change in the existing law. That a proposal entails risk of mistake is hardly a conclusive reason against it. But neither is it irrelevant. Under any euthanasia program the consequences of mistake, of course, are always fatal. As I shall endeavor to show, the incidence of mistake of one kind or another is likely to be quite appreciable. If this indeed be the case, unless the need for the authorized conduct is compelling enough to override it, I take it the risk of mistake is a conclusive reason against such authorization. I submit too, that the possible radiations from the proposed legislation, *e.g.*, involuntary euthanasia of idiots and imbeciles (the typical "mercy-killings" reported by the press) and the emergence of the legal precedent that there are lives not "worth living," give additional cause to pause.

I see the issue, then, as the need for voluntary euthanasia versus (1) the incidence of mistake and abuse; and (2) the danger that legal machinery initially designed to kill those who are a nuisance to themselves may someday engulf those who are a nuisance to others.²⁶

The "freedom to choose a merciful death by euthanasia" may well be regarded, as does Professor Harry Kalven in a carefully measured review of another recent book urging a similar proposal,²⁷ as "a special area of civil liberties far removed from the familiar concerns with criminal procedures, race discrimination and freedom of speech and religion."²⁸ The civil liberties angle is definitely a part of Professor Williams' approach:

25. Williams, p. 339.

26. Cf. G. K. Chesterton, *Euthanasia and Murder*, 8 Am. Rev. 486, 490, (1937).

27. See Fletcher, *op. cit. supra*, note 8.

28. Kalven, *supra* note 7. I would qualify this statement only by the suggestion that to some extent this freedom may be viewed as an aspect of the freedom of religion of the non-Believer. For a consideration of the problems raised by organizations which claim to be "religious" but do not require their adherents to believe in a Supreme Being, see *Washington Ethical Soc'y v. District of Columbia*, 249 F.2d 127 (D.C. Cir. 1957); *Fellowship of Humanity v. County of Alameda*, 315 P.2d 394 (Cal. App. 1957), 58 Colum. L. Rev. 417 (1958).

Undoubtedly the most extreme expression of this view is the bitter comment of Viscount Esher, upon concluding from the run of the speeches that he and his allies would be overwhelmed in the House of Lords debate on the question (169 H.L. Deb. [5th ser.] 551, 574-76 [1950]):

[Voluntary euthanasia] is certainly an evolutionary extension of liberty of great importance, giving to the individual new rights to which, up till now, he has not had access. . . . What we propose this afternoon is, in point of fact, a new freedom, and undoubtedly it will antagonize the embattled forces of the official world. . . . I believe that posterity will look back on this refusal you are going to make this afternoon . . . as

If the law were to remove its ban on euthanasia, the effect would merely be to leave this subject to the individual conscience. This proposal would . . . be easy to defend, as restoring personal liberty in a field in which men differ on the question of conscience. . . .

On a question like this there is surely everything to be said for the liberty of the individual.²⁹

I am perfectly willing to accept civil liberties as the battlefield, but issues of "liberty" and "freedom" mean little until we begin to pin down *whose* "liberty" and "freedom" and for *what* need and at *what* price. This paper is concerned largely with such questions.

It is true also of journeys in the law that the place you reach depends on the direction you are taking. And so, where one comes out on a case depends on where one goes in.³⁰

So it is with the question at hand. Williams champions the "personal liberty" of the dying to die painlessly. I am more concerned about the life and liberty of those who would needlessly be killed in the process or who would irrationally choose to partake of the process. Williams' price on behalf of those who are *in fact* "hopeless incurables" and *in fact* of a fixed and rational desire to die is the sacrifice of (1) some few, who, though they know it not, because their physicians know it not, need not and should not die; (2) others, probably not so few, who, though they go through the motions of "volunteering", are casualties of strain, pain or narcotics to such an extent that they really know not what they do. My price on behalf of those who, despite appearances to the contrary, have some relatively normal and reasonably useful life left in them, or who are incapable of making the choice, is the lingering on for awhile of those who, if you will, *in fact* have no desire and no reason to linger on.

people look now on the burning of witches—as a barbarous survival of mediaeval ideas, an example of that high-minded cruelty from the entanglement of which it has taken mankind so many centuries to emerge. In that day we few, we five or six shall, I believe, be remembered.

At the end, the euthanasiasts avoided a vote by withdrawing the question, *id.* at 598. In an earlier House of Lords debate, proposed voluntary euthanasia legislation was defeated by a 35-14 vote. 103 H. L. Deb. (5th ser.) 466, 506 (1936).

29. Williams, pp. 341, 346.

30. Frankfurter, J., dissenting in *United States v. Rabinowitz*, 339 U.S. 56, 69 (1950).

Perhaps as good an example as any may be taken from Glanville Williams' own text, *Criminal Law: The General Part* § 180 (1953). With a deep concern for the *parents'* "freedom not to conform" as his starting point, Williams makes a strong policy argument for immunizing from criminal law sanctions those "peculiar people" who for sincere religious reasons fail to summon medical aid to their sick children. One who takes the health and welfare of *children* as his starting point might well reach a somewhat different conclusion.

I. A CLOSE-UP VIEW OF VOLUNTARY EUTHANASIA

A. *The Euthanasias' Dilemma and Williams' Proposed Solution.*

As if the general principle they advocate did not raise enough difficulties in itself, euthanasias have learned only too bitterly that specific plans of enforcement are often much less palatable than the abstract notions they are designed to effectuate. In the case of voluntary euthanasia, the means of implementation vary from (1) the simple proposal that mercy-killings by anyone, typically relatives, be immunized from the criminal law; to (2) the elaborate legal machinery contained in the bills of the Voluntary Euthanasia Legalisation Society (England) and the Euthanasia Society of America for carrying out euthanasia.

The English Society would require the eligible patient, *i.e.*, one over twenty-one and "suffering from a disease involving severe pain and of an incurable and fatal character,"³¹ to forward a specially prescribed application — along with two medical certificates, one signed by the attending physician, and the other by a specially qualified physician — to a specially appointed Euthanasia Referee "who shall satisfy himself by means of a personal interview with the patient and otherwise that the said conditions shall have been fulfilled and that the patient fully understands the nature and purpose of the application"; and, if so satisfied, shall then send a euthanasia permit to the patient; which permit shall, seven days after receipt, become "operative" in the presence of an official witness; unless the nearest relative manages to cancel the permit by persuading a court of appropriate jurisdiction that the requisite conditions have not been met.

The American Society would have the eligible patient, *i.e.*, one over twenty-one "suffering from severe physical pain caused by a disease for which no remedy affording lasting relief or recovery is at the time known to medical science,"³² petition for euthanasia in the presence of two witnesses and file same, along with the certificate of an attending physician, in a court of appropriate jurisdiction; said court to then appoint a committee of three, of whom at least two must be physicians, "who shall forthwith examine the patient and such other persons as they deem advisable or as the court may direct and within five days after their appointment, shall report to

31. Section 2(1) of the English Bill. The full text is set forth in Roberts, *Euthanasia and Other Aspects of Life and Death* 21-26 (1936).

32. Section 301 of the American Bill. The full text is set forth in Sullivan, *The Morality of Mercy Killing* 25-28 (1950). Fletcher, *op. cit. supra* note 3, at 187, regards this bill as "perhaps the model legislation." Such bills have been unsuccessfully introduced in the legislatures of Nebraska, N.Y. Times, Feb. 3, 1937, p. 7, col. 1; Feb. 14, 1937, p. 17, col. 1; and, some ten years later, New York, Fletcher at 184-85.

the court whether or not the patient understands the nature and purpose of the petition and comes within the [act's] provisions"; whereupon, if the report is in the affirmative, the court shall — "unless there is some reason to believe that the report is erroneous or untrue" — grant the petition; in which event euthanasia is to be administered in the presence of the committee, or any two members thereof.

As will be seen, and as might be expected, the simple negative proposal to remove "mercy-killings" from the ban of the criminal law is strenuously resisted on the ground that it offers the patient far too little protection from not-so-necessary or not-so-merciful killings. On the other hand, the elaborate affirmative proposals of the euthanasia societies meet much pronounced eye-blinking, not a few guffaws,³³ and sharp criticism that the legal machinery is so drawn-out, so complex, so formal and so tedious as to offer the patient far too little solace.

33. I venture to say there are few men indeed who will not so much as smile at the portion of the American Society's Bill, Sullivan *op. cit. supra*, note 3 at 28, which provides that if the petition for euthanasia shall be denied by a Justice of the Supreme Court, "an appeal may be taken to the appellate division of the supreme court, and/or to the Court of Appeals".

34. Royal Commission on Capital Punishment, Report, Cmd. No. 8932, at para. 179 (1953). Cf. Bentham, *The Theory of Legislation* 256 (Ogden ed. 1931):

Let us recollect that there is no room for considering the motive except when it is manifest and palpable. It would often be very difficult to discover the true or dominant motive, when the action might be equally produced by different motives, or where motives of several sorts might have cooperated in its production. In the interpretation of these doubtful cases it is necessary to distrust the malignity of the human heart, and that general disposition to exhibit a brilliant sagacity at the expense of good nature. We involuntarily deceive even ourselves as to what puts us into action. In relation even to our own motives we are wilfully blind, and are always ready to break into a passion against the oculist who desires to remove the cataract of ignorance and prejudice.

Cf. Roberts, *op. cit. supra* note 31, at 10-11:

Self-deception as to one's motives, what the psychologists call 'rationalization', is one of the most powerful of man's self-protective mechanisms. It is an old observation of criminal psychologists that the day-dreamers and the rationalizers account for a very large proportion of the criminal population; whilst, in murderers, this habit of self-deception is often carried to incredible lengths.

It should be noted, however, that the likelihood of faked mercy-killings would seem to be substantially reduced when such acts are not completely immunized but only categorized as a lesser degree of criminal homicide. If mercy killings were simply taken out of the category of murder, a second line of defense might well be the appearance of a mercy-killing but in planned murders generally the primary concern of the murderer must surely be to escape all punishment whatever, not to give a serious, but not the most serious, appearance to his act, not to substitute a long period of imprisonment for execution. Cf. the discussion of faked suicide pacts in Royal Commission, *supra*, Minutes of Evidence, paras. 804-07. As was stated at the outset, however, see note 7, *supra*, this paper deals with proposals to completely legalize mercy-killings, not with the advisability of taking it out of the category of murder.

The naked suggestion that mercy-killing be made a good defense against a charge of criminal homicide appears to have no prospect of success in the foreseeable future. Only recently, the Royal Commission on Capital Punishment "reluctantly" concluded that such homicides could not feasibly be taken out of the category of murder, let alone completely immunized:

[Witnesses] thought it would be most dangerous to provide that 'mercy killings' should not be murder, because it would be impossible to define a category which could not be seriously abused. Such a definition could only be in terms of the motive of the offender . . . which is notoriously difficult to establish and cannot, like intent, be inferred from a person's overt actions. Moreover it was agreed by almost all witnesses, including those who thought that there would be no real difficulty in discriminating between genuine and spurious suicide pacts, that, even if such a definition could be devised, it would in practice often prove extremely difficult to distinguish killings where the motive was merciful from those where it was not. How, for example, were the jury to decide whether a daughter had killed her invalid father from compassion, from a desire for material gain, from a natural wish to bring to an end a trying period of her life, or from a combination of motives?³⁴

While the appeal in simply taking "mercy-killings" off the books is dulled by the likelihood of abuse, the force of the idea is likewise substantially diminished by the encumbering protective features proposed by the American and English Societies. Thus, Lord Dawson, an eminent medical member of the House of Lords and one of the great leaders of the English medical profession, protested that the English Bill "would turn the sick room into a bureau," that he was revolted by "the very idea of the sick chamber being visited by officials and the patient, who is struggling with this dire malady, being treated as if it was a case of insanity."³⁵ Dr. A. Leslie Banks, then Principal Medical Officer of the Ministry of Health, reflected that the proposed machinery would "produce an atmosphere quite foreign to all accepted notions of dying in peace."³⁶ Dr. I. Phillips Frohman has similarly objected to the American Bill as one whose "whole procedure is so lengthy that it does not seem consonant either with the 'mercy' motive on which presumably it is based, or with the 'bearableness' of the pain."³⁷

The extensive procedural concern of the euthanasia bills have repelled many, but perhaps the best evidence of its psychological misconception is that it has distressed sympathizers of the move-

35. 103 H.L. Deb. (5th ser.) 484-85 (1936).

36. Banks, *Euthanasia*, 161 Practitioner 101, 104 (1948).

37. Frohman, *Vexing Problems in Forensic Medicine: A Physician's View*, 31 N.Y.U.L. Rev. 1215, 1222 (1956).

ment as well. The very year the English Society was organized and a proposed bill drafted, Dr. Harry Roberts observed:

We all realize the intensified horror attached to the death-penalty by its accompanying formalities—from the phraseology of the judge's sentence, and his black cap, to the weight-gauging visit of the hangman to the cell, and the correct attendance at the final scene of the surpliced chaplain, the doctor, and the prison governor. This is not irrelevant to the problem of legalized euthanasia...³⁸

After discussing the many procedural steps of the English Bill Dr. Roberts observed: "I can almost hear the cheerful announcement: 'please, ma'am, the euthanizer's come.'"

At a meeting of the Medico-Legal Society, Dr. Kenneth McFadyean, after reminding the group that "some time ago he stated from a public platform that he had practiced euthanasia for twenty years and he did not believe he was running risks because he had helped a hopeless sufferer out of this life," commented on the English Bill:

There was no comparison between being in a position to make a will and making a patient choose his own death at any stated moment. The patient had to discuss it—not once with his own doctor, but two, three, or even four times with strangers, which was no solace or comfort to people suffering intolerable pain.³⁹

Nothing rouses Professor Williams' ire more than the fact that opponents of the euthanasia movement argue that euthanasia proposals offer either inadequate protection or overelaborate safeguards. Williams appears to meet this dilemma with the insinuation that because arguments are made in the antithesis *they must each be invalid, each be obstructionist, and each be made in bad faith.*⁴⁰

It just may be, however, that each alternative argument is quite valid, that the trouble lies with the euthanasiasts themselves in seeking a goal which is *inherently inconsistent*: a procedure for

38. Roberts, *op. cit. supra* note 31, at 14-15.

39. Earengay, *Voluntary Euthanasia*, 8 Medico-Legal & Crim. Rev. 91, 106 (1940) (discussion following the reading of Judge Earengay's paper).

40. Williams, p. 334:

The promoters of the bill hoped that they might be able to mollify the opposition by providing stringent safeguards. Now, they were right in thinking that if they had put in no safeguards—if they had merely said that a doctor could kill his patient whenever he thought it right—they would have been passionately opposed on this ground. So they put in the safeguards.

* * *

Did the opposition like these elaborate safeguards? On the contrary, they made them a matter of complaint. The safeguards would, it was said, bring too much formality into the sick-room, and destroy the relationship between doctor and patient. So the safeguards were wrong, but no one of the opposition speakers said that he would have voted for the bill without the safeguards.

death which *both* (1) provides ample safeguards against abuse and mistake; and (2) is "quick" and "easy" in operation. Professor Williams meets the problem with more than bitter comments about the tactics of the opposition. He makes a brave try to break through the dilemma:

[T]he reformers might be well advised, in their next proposal, to abandon all their cumbrous safeguards and to do as their opponents wish, giving the medical practitioner a wide discretion and trusting to his good sense.

[T]he essence of the bill would then be simple. It would provide that no medical practitioner should be guilty of an offense in respect of an act done intentionally to accelerate the death of a patient who is seriously ill, unless it is proved that the act was not done in good faith with the consent of the patient and for the purpose of saving him from severe pain in an illness believed to be of an incurable and fatal character. Under this formula it would be for the physician, if charged, to show that the patient was seriously ill, but for the prosecution to prove that the physician acted from some motive other than the humanitarian one allowed to him by law.⁴¹

41. *Id.* at 339-40. The desire to give doctors a free hand is expressed numerous times:

[T]here should be no formalities and . . . everything should be left to the discretion of the doctor (p. 340). . . . the bill would merely leave this question to the discretion and conscience of the individual medical practitioner. (p. 341). . . . It would be the purpose of the proposed legislation to set doctors free from the fear of the law so that they can think only of the relief of their patients (p. 342). . . . It would bring the whole subject within ordinary medical practice. (*Ibid.*)

Williams suggests that the pertinent provisions might be worded as follows (345):

1. For the avoidance of doubt, it is hereby declared that it shall be lawful for a physician whose patient is seriously ill—

* * *

b. to refrain from taking steps to prolong the patient's life by medical means;

—unless it is proved that . . . the omission was not made, in good faith for the purpose of saving the patient from severe pain in an illness believed to be of an incurable and fatal character.

2. It shall be lawful for a physician, after consultation with another physician, to accelerate by any merciful means the death of a patient who is seriously ill, unless it is proved that the act was not done in good faith with the consent of the patient and for the purpose of saving him from severe pain in an illness believed to be of an incurable and fatal character.

The completely unrestricted authorization to kill by omission may well be based on Williams' belief, at 326, that under existing law "mercy-killing" by omission to prolong life is probably lawful" since the physician is "probably exempted" from the duty to use reasonable care to conserve his patient's life "if life has become a burden." And he adds—as if this settles the legal question—that "the morality of an omission in these circumstances is conceded even by Catholics." *Ibid.*

If Williams means, as he seems to, that once a doctor has undertaken treatment and the patient is entrusted solely to his care he may sit by the bedside of the patient whose life has "become a burden" and let him die, *e.g.*, by not replacing the oxygen bottle, I submit that he is quite mistaken.

The outerlimits of criminal liability for inaction are hardly free from doubt, but it seems fairly clear under existing law that the special and traditional relationship of physician and patient imposes a "legal duty to act," particularly where the patient is helpless, and completely dependent on the physician, and that the physician who withholds life-preserving medical means of the type described above commits criminal homicide by omission. In this regard, see 2 Burdick, *Crimes* § 466c (1946); Hall, *Principles of Criminal Law* 272-78 (1947); Kenny, *Outlines of Criminal Law* 14-15, 107-09 (16th ed. Turner 1952); Perkins, *Criminal Law* 513-27 (1957); 1 Russell, *Crime* 449-66 (10th ed. Turner 1950); Hughes, *Criminal Omissions*, 67 *Yale L.J.* 590, 599-600, 621-26, 630 n. 142 (1958); Kirchheimer, *Criminal Omissions*, 55 *Harv. L. Rev.* 615, 625-28 (1942); Wechsler and Michael, *supra* note 5 at 724-25.

Nor am I at all certain that the Catholics do "concede" this point. Williams' reference is to Sullivan, *op. cit. supra* note 3, at 64. But Sullivan considers therein what might be viewed as relatively remote and indirect omissions, *e.g.*, whether to call in a very expensive specialist, whether to undergo a very painful or very drastic operation.

The Catholic approach raises nice questions and draws fine lines. *E.g.*, how many limbs must be amputated before an operation is to be regarded as a non-obligatory "extraordinary," as opposed to "ordinary" means, but they will not be dwelt upon herein. Suffice to say that apparently there has never been an indictment, let alone a conviction, for a "mercy-killing" by omission, not even one which directly and immediately produces death.

This, of course, is not to say that no such negative "mercy-killings" have ever occurred. There is reason to think that not too infrequently this is the fate of the defective newborn infant. Williams, at 22, simply asserts that the "beneficent tendency of nature [in that "monsters" usually die quickly after birth] is assisted, in Britain at any rate, by the practice of doctors and nurses, who, when an infant is born seriously malformed, do not 'strive officiously to keep alive.'" Fletcher, at 207 n. 54, makes a similar and likewise undocumented observation that "it has always been a quite common practice of midwives and, in modern times doctors simply to fail to resuscitate monstrous babies at birth." A supposition to the same effect was made twenty years earlier in Gregg, *The Right To Kill*, 237 *No. Am. Rev.* 239, 242 (1934). A noted obstetrician and gynecologist, Dr. Frederic Loomis, has told of occasions where expectant fathers have, in effect, asked him to destroy the child, if born abnormal. Loomis, *Consultation Room* 53 (1946). For an eloquent presentation of the problem raised by the defective infant see *id.* at 53-64.

It is difficult to discuss the consultation feature of Williams' proposal for affirmative "mercy-killing" because Williams himself never discusses it. This fact, plus the fact that Williams' recurrent theme is to give the general practitioner a free hand indicates that he himself does not regard consultation as a significant feature of his plan. The attending physician need only consult another general practitioner and there is no requirement that there be any concurrence in his diagnosis. There is no requirement of a written report. There is no indication as to what point in time there need be consultation. Probably there need be consultation only as to diagnosis of the disease and from that point on the extent and mitigatory nature of the pain, and the firmness and rationality of the desire to die is to be judged solely by the attending physician. For the view that even under rather elaborate consultation requirements, in many thinly staffed communities the consulted doctor would merely reflect the view of the attending physician see *Life and Death*, *Time*, March 13, 1950, p. 50. After reviewing eleven case histories of patients wrongly diagnosed as having advanced cancer, diagnoses that stood uncorrected over long periods of time and after several admissions at leading hospitals, Doctors Laszlo, Colner, Silver and Standard conclude: [*Errors in Diagnosis And Management of Cancer*, 33 *Annals Int. Med.* 670 (1950)]:

[I]t became increasingly clear that the original error was one easily made, but that the continuation of that error was due to an acceptance of the original data without exploring their verity and completeness.

Evidently, the presumption is that the general practitioner is a sufficient buffer between the patient and the restless spouse or overwrought or overreaching relative, as well as a depository of enough general scientific know-how and enough information about current research developments and trends, to assure a minimum of error in diagnosis and anticipation of new measures of relief. Whether or not the general practitioner will accept the responsibility Williams would confer on him is itself a problem of major proportions.⁴²

42. In taking the Hippocratic Oath, the oldest code of professional ethics, the physician promises, of course, to "give no deadly medicine to any one if asked, nor suggest any such counsel." Many doctors have indicated they would not accept the role in which legalized euthanasia would cast them. See, e.g., Frohman, *supra* note 37, at 1221 ("I could never deliberately choose the time of another's dying. The preservation of human life is not only the primary but the all-encompassing general law underlying the code of the physician. . . . Do not ask life's guardian to be also its executioner."); Gumpert, *A False Mercy*, 170 *The Nation* 80 (1950). ("As a physician, I feel I would have to reject the power and responsibility of the ultimate decision"); Lord Haden-Guest, 169 H.L. Deb. [5th ser.] 551, 586 [1950] ("You are asking the medical profession to do it. Ask somebody else."), Kennedy, *Euthanasia: To Be or Not To Be*, *Colliers*, May 20, 1939, pp. 15, 57, reprinted in *Colliers*, April 22, 1950, pp. 13, 50 ("Who is going to carry out the sentence of death? I am sure not I. . . . too grisly a notion for the profession of medicine to stomach"). In 1950, a banner year for mercy-killing trials (see the *Mohr* case, *supra* note 17, and the *Sander, Paight* and *Braunsdorf* cases at notes 172-176, 183 *infra* and accompanying text) the General Assembly of the World Medical Association approved a resolution recommending to all national associations that they "condemn the practice of euthanasia under any circumstances." *New York Times*, Oct. 18, 1950, p. 22, col. 4. Earlier that year, the Medical Society of the State of New York went on record as being "unalterably opposed to euthanasia and to any legislation which will legalize euthanasia." *New York Times*, May 10, 1950, p. 29, col. 1.

On the other hand, euthanasiasts claim their movement finds great support in the medical profession. The most impressive and most frequently cited piece of evidence is the formation, in 1946, of a committee of 1,776 physicians for the legalization of voluntary euthanasia in New York. See Williams at 331; Fletcher, *op. cit. supra* note 3, at 187. Williams states that of 3,272 physicians who replied to a questionnaire in New York State in 1946, 80 per cent approved voluntary euthanasia and the Committee of 1,776 came from among this favorable group. I have been unable to find any authority for the 80 per cent figure, and Williams cites none. Some years ago, Gertrude Anne Edwards, then editor of the *Euthanasia Society Bulletin*, claimed 3,272 physicians—apparently all who replied—favored legalizing voluntary euthanasia. Edwards, *Mercy Death For Incurables Should Be Made Legal*, *The Daily Compass*, Aug. 24, 1949, p. 8, col. 1 (issue of the day). Presumably, as in the case of the recent New Jersey questionnaire discussed below, every physician in New York was sent a questionnaire. If so, then the figures cited, whether Williams or Edwards, would mean a great deal more (and support the euthanasiasts a great deal less) if it were added that 88 or 89 per cent of the physicians in the state did not reply at all. In 1940, there were over 26,000 physicians in the State of New York, U.S. Department of Commerce, Bureau of the Census, *The Labor Force*, Part 4 at 366; in 1950 there were over 30,000, U.S. Dep't of Commerce, Bureau of the Census, *Characteristics of the Population*, Part 32 at 260.

The most recent petition of physicians for legalized euthanasia was that signed by 166 New Jersey physicians early in 1957 urging in effect the adoption of the American Society's Bill. See Anderson, *Who Signed for*

Putting that question aside, the soundness of the underlying premises of Williams' "legislative suggestion" will be examined in the course of the discussion of various aspects of the euthanasia problem.

B. The "Choice."

Under current proposals to establish legal machinery, elaborate or otherwise, for the administration of a quick and easy death, it is not enough that those authorized to pass on the question decide that the patient, in effect, is "better off dead." The patient must concur in this opinion. Much of the appeal in the current proposal lies in this so-called "voluntary" attribute.

But is the adult patient⁴³ really in a position to concur? Is he truly able to make euthanasia a "voluntary" act? There is a good deal to be said, is there not, for Dr. Frohman's pithy comment that

Euthanasia? 96 *America* 573 (1957). According to this article, the American Society had sent a letter to *all* the doctors in the state asking them to sign such a petition. The doctors were asked to check either of two places, one indicating that their name could be used, the other that it could not. The 1950 census records over 7,000 physicians in New Jersey. Characteristics of the Population, Part 30 at 203. Thus, about 98 per cent of the state medical profession *declined* to sign such a petition. The Medical Society of New Jersey immediately issued a statement that "euthanasia has been and continues to be in conflict with accepted principles of morality and sound medical practice." See Anderson, *supra*. When their names were published in a state newspaper, many of the 166 claimed they had not signed the petition or that they had misunderstood its purpose or that, unknown to them, some secretary had handled the matter in a routine manner. See Anderson, *supra*.

Cf. Paragraph 27 of the Memorandum submitted by the Council of the British Medical Association (Royal Commission, Minutes of Evidence at p. 318):

In the opinion of the Association, no medical practitioner should be asked to take part in bringing about the death of a convicted murderer. The Association would be most strongly opposed to any proposal to introduce, in place of judicial hanging, a method of execution which would require the services of a medical practitioner, either in carrying out the actual process of killing or in instructing others in the technique of the process.

Examination of medical witnesses disclosed that they opposed execution by intravenous injection as "a matter of professional ethics" since "under oath we are bound to promote life . . . whereas any action which has as its object the termination of life, even directly, we feel is undesirable." *Id.* at para. 4041 (Feb. 3, 1950). See also para. 4 of the Memorandum of the Association of Anaesthetists to the effect that if intravenous injection is adopted as an alternative method of execution "the executioner should have no connection or association with the medical profession." *Id.* at p. 678A. For a general discussion of the problem and the views of the medical profession on the matter, see Royal Commission Report at paras. 737-748. Apparently the American medical profession has the same reluctance to participate in execution by intravenous injection. See Weihofen, *The Urge to Punish* 168 (1956).

43. It should be noted that under what might be termed the "family plan" feature of Williams' proposal, minors may be euthanatized, too. Their fate is to be "left to the good sense of the doctor, taking into account, as he always does, the wishes of the parents as well as those of the child." Williams, p. 340, n. 8. The dubious quality of the "voluntariness" of euthanasia in these circumstances need not be labored.

the "voluntary" plan is supposed to be carried out "only if the victim is both sane and crazed by pain."⁴⁴

By hypothesis, voluntary euthanasia is not to be resorted to until narcotics have long since been administered and the patient has developed a tolerance to them. *When*, then, does the patient make the choice? While heavily drugged?⁴⁵ Or is narcotic relief to

44. Frohman, *Vexing Problems In Forensic Medicine: A Physician's View*, 31 N.Y.U.L. Rev. 1215, 1222 (1956).

45. The disturbing mental effects of morphine, "the classic opiate for the relief of severe pain," Schiffrin and Gross, *Systematic Analgetics*, in *Management Of Pain In Cancer* p. 22 (Schiffrin ed. 1956) and "still the most commonly used potent narcotic analgesic in treatment of cancer pain," Bonica, *The Management of Cancer Pain*, G.P., Nov. 1954, pp. 35, 39, have been described in considerable detail by Drs. Wolff, Hardy and Goodell in *Studies on Pain: Measurement of the Effect of Morphine, Codeine, and other Opiates on the Pain Threshold and an Analysis of their Relation to the Pain Experience*, 19 J. Clinical Investig. 659, 664 (1940). It is not easy to generalize about the psychological effects of drugs for there is good reason to believe that the type of drug reaction is correlated with "differential personality dynamics, primarily in terms of the balance of mature, socially oriented controls over impulsive, egocentric emotionality," von Felsinger, Lasagna and Beecher, *Drug-Induced Mood Changes in Man*, 157 A.M.A.J. 1113, 1119 (1955), that for example, persons with atypical reactions to drugs are likely to be those with pre-existing immaturity, anxiety and hostility, *id.* at 1116. See also Lindemann and Clark, *Modifications In Ego Structure and Personality Reactions Under the Influence of the Effects of Drugs*, 108 Am. J. Psychiatry 561 (1952). It would seem, however, that the severely ill person would be likely to experience substantially more pronounced effects than those described by Wolff, Hardy and Goodell, *supra*, because in that instance the "subjects" studied were the authors themselves, representing both sexes and different body types, experiencing various degrees of pain by exposing portions of their skin surfaces to thermal radiation, but in the case of an illness due to a malignancy or suspected malignancy, we start with a situation where "all kinds of irrational attitudes come to the fore". Zarling, *Psychological Aspects of Pain In Terminal Malignancies*, in *Management of Pain in Cancer* 205 (Schiffrin ed. 1956).

The increasing use of ACTH or cortisone therapy in cancer palliation, see notes 98-101, *infra* and accompanying text, presents further problems. Such therapy "frequently" leads to a "severe degree of disturbance in capacity for rational, sequential thought." Lindemann and Clark, *supra* at 566. Clark, *et. al.*, *Preliminary Observations On Mental Disturbances Occurring In Patients under Therapy With Cortisone and ACTH*, 246 N. Eng. J. Med. 205, 215 (1952) describe six case histories of "major disturbances" where "delusions of depressive, paranoid and grandiose types occurred" and "affective disturbances, also invariably present, varied from depression to hypomania and from apathy to panic; they included ill-defined states that might be described as bewilderment or turmoil." In a subsequent paper, the authors conclude, Clark, *et. al.*, *Further Observations On Mental Disturbances Associated With Cortisone and ACTH Therapy*, 249 N. Eng. J. Med. 178, 182 (1953) that the clinical course of psychoses associated with ACTH and cortisone is "more remarkable for its variability and unpredictability than any other feature," that, for example, mental disturbances may be separated by "intervals of relative lucidity," that "patients may have tolerated previous courses of ACTH or cortisone without complications and yet become psychotic during a subsequent course of treatment with comparable or even smaller doses."

For an extensive review of the many hypotheses purporting to explain mental disturbances associated with ACTH and cortisone see Quarton, *et. al.*, *Mental Disturbances Associated with ACTH and Cortisone: A Review of*

be withdrawn for the time of decision? But if heavy dosage no longer deadens pain, indeed, no longer makes it bearable, how overwhelming is it when whatever relief narcotics offer is taken away, too?

"Hypersensitivity to pain after analgesia has worn off is nearly always noted."⁴⁶ Moreover, "the mental side-effects of narcotics, unfortunately for anyone wishing to suspend them temporarily without unduly tormenting the patient, appear to outlast the analgesic effect" and "by many hours."⁴⁷ The situation is further complicated by the fact that "a person in terminal stages of cancer who had been given morphine steadily for a matter of weeks would certainly be dependent upon it physically and would probably be addicted to it and react with the addict's response."⁴⁸

The narcotics problem aside, Dr. Benjamin Miller, who probably has personally experienced more pain than any other commentator on the euthanasia scene,⁴⁹ observes:

Anyone who has been severely ill knows how distorted his judgment became during the worst moments of the illness. Pain and the toxic effect of disease, or the violent reaction to certain surgical procedures may change our capacity for rational and courageous thought.⁵⁰

If, say, a man in this plight were a criminal defendant and he were to decline the assistance of counsel would the courts hold that he had

Explanatory Hypotheses, 34 Med. 13 (1955). The authors emphasize the inadequacy of present knowledge of mental disturbances associated with this therapy, but believe, "because of the clinical and experimental studies which suggest it," that "it is useful to assume" "cortisone and ACTH produce a ['probably reversible'] specific pattern of modified nervous system function which is invariably present when a gross mental disturbance occurs," *id.* at 41.

46. Goodman and Gilman, *The Pharmacological Basis of Therapeutics* 235 (2d ed. 1955). To the same effect is Seevers and Pfeiffer, *A Study of the Analgesia, Subjective Depression, and Euphoria Produced by Morphine, Heroine, Dilaudid and Codeine In the Normal Human Subject*, 56 J. Pharm. & Exper. Therap. 166, 182, 187 (1936).

47. Sharpe, *Medication As A Threat To Testamentary Capacity*, 35 N.C. L. Rev. 380, 392 (1957) and medical authorities cited therein.

In the case of cortisone or ACTH therapy, the situation is complicated by the fact that "a frequent pattern of recovery" from psychoses induced by such therapy is "by the occurrence of lucid intervals of increasing frequency and duration, punctuated by relapses into psychotic behavior." Clark, et. al., *Further Observations On Mental Disturbances Associated With Cortisone and ACTH Therapy*, 249 N. Eng. J. Med. 178, 183, (1953).

48. Sharpe, *supra*, note 47, at 384. Goodman and Gilman, *op. cit.*, *supra*, note 46 at 234, observe that while "different individuals require varying periods of time before the repeated administration of morphine results in tolerance, . . . as a rule . . . after about two to three weeks of continued use of the same dose of alkaloid the usual depressant effects fail to appear" whereupon "phenomenally large doses may be taken." For a discussion of "the nature of addiction," see Maurer and Vogel, *Narcotics and Narcotic Addiction* 20-31 (1954).

49. See note 77 *infra* and accompanying text.

50. Miller, *Why I Oppose Mercy Killings*, *Woman's Home Companion*, June 1950, pp. 38, 103.

"intelligently and understandingly waived the benefit of counsel?"⁵¹

Undoubtedly, some euthanasia candidates will have their lucid moments. How they are to be distinguished from fellow-sufferers who do not, or how these instances are to be distinguished from others when the patient is exercising an irrational judgment is not an easy matter. Particularly is this so under Williams' proposal, where no specially qualified persons, psychiatrically trained or otherwise, are to assist in the process.

Assuming, for purposes of argument, that the occasion when a euthanasia candidate possesses a sufficiently clear mind can be ascertained and that a request for euthanasia is then made, there remain other problems. The mind of the pain-racked may occasionally be clear, but is it not also likely to be uncertain and variable? This point was pressed hard by the great physician, Lord Horder, in the House of Lords debates:

During the morning depression he [the patient] will be found to favour the application under this Bill, later in the day he will think quite differently, or will have forgotten all about it. The mental clarity with which noble Lords who present this Bill are able to think and to speak must not be thought to have any counterpart in the alternating moods and confused judgments of the sick man.⁵²

The concept of "voluntary" in voluntary euthanasia would have a great deal more substance to it if, as is the case with voluntary admission statutes for the mentally ill,⁵³ the patient retained the right to reverse the process within a specified number of days after he gives written notice of his desire to do so — but unfortunately this cannot be. The choice here, of course, is an irrevocable one.

The likelihood of confusion, distortion or vacillation would appear to be serious draw-backs to any voluntary plan. Moreover, Williams' proposal is particularly vulnerable in this regard, since, as he admits, by eliminating the fairly elaborate procedure of the American and English Societies' plans, he also eliminates a time period which would furnish substantial evidence of the patient's

51. *Moore v. Michigan*, 355 U.S. 155, 161 (1957).

52. 103 H. L. Deb. (5th ser.) 466, 492-93 (1936). To the same effect is Lord Horder's speech in the 1950 debates, 169 H. L. Deb. (5th ser.) 551, 569 (1950). See also Gumpert, *A False Mercy*, 170 *The Nation* 80 (1950): Even the incapacitated, agonized patient in despair most of the time, may still get some joy from existence. His mood will change between longing for death and fear of death. Who would want to decide what should be done on such unsafe ground?

For a recent layman's account of the self-pity and fluctuating desires for life and death of a seriously ill person, see the reflections of the famous sports broadcaster Ted Husing in *My Friends Wouldn't Let Me Die*, Look, Feb. 4, 1958, p. 64.

53. See Guttman and Weihofen, *Psychiatry and the Law* 307 (1952).

settled intention to avail himself of euthanasia.⁵⁴ But if Williams does not always choose to slug it out, he can box neatly and parry gingerly:

[T]he problem can be exaggerated. Every law has to face difficulties in application, and these difficulties are not a conclusive argument against a law if it has a beneficial operation. The measure here proposed is designed to meet the situation where the patient's consent to euthanasia is clear and incontrovertible. The physician, conscious of the need to protect himself against malicious accusations, can devise his own safeguards appropriate to the circumstances; he would normally be well advised to get the patient's consent in writing, just as is now the practice before operations. Sometimes the patient's consent will be particularly clear because he will have expressed a desire for ultimate euthanasia while he is still clear-headed and before he comes to be racked by pain; if the expression of desire is never revoked, but rather is reaffirmed under the pain, there is the best possible proof of full consent. If, on the other hand, there is no such settled frame of mind, and if the physician chooses to administer euthanasia when the patient's mind is in a variable state, he will be walking in the margin of the law and may find himself unprotected.⁵⁵

If consent is given at a time when the patient's condition has so degenerated that he has become a fit candidate for euthanasia, when, if ever, will it be "clear and incontrovertible?" Is the suggested alternative of consent in advance a satisfactory solution? Can such a consent be deemed an informed one? Is this much different from holding a man to a prior statement of intent that if such and such an employment opportunity would present itself he would accept it, or if such and such a young woman were to come along he would marry her? Need one marshal authority for the proposition that many an "iffy" inclination is disregarded when the actual facts are at hand?⁵⁶

Professor Williams states that where a pre-pain desire for "ultimate euthanasia" is "reaffirmed" under pain, "there is the best

54. Williams, pp. 343-44.

55. *Id.* at 344.

56. Dr. James J. Walsh in *Life Is Sacred*, 94 *The Forum*, 333, 333-34, recalls the following Aesop's fable:

It was a bitter-cold day in the wintertime, and an old man was gathering broken branches in the forest to make a fire at home. The branches were covered with ice, many of them were frozen and had to be pulled apart, and his discomfort was intense. Finally the poor old fellow became so thoroughly wrought up by his suffering that he called loudly upon death to come. To his surprise, Death came at once and asked what he wanted. Very hastily the old man replied, 'Oh, nothing; nothing except to help me carry this bundle of sticks home so that I may make a fire.'

possible proof of full consent." Perhaps. But what if it is alternately renounced and reaffirmed under pain? What if it is neither affirmed or renounced? What if it is only renounced? Will a physician be free to go ahead on the ground that the prior desire was "rational", but the present desire "irrational"? Under Williams' plan, will not the physician frequently "be walking in the margin of the law" — just as he is now? Do we really accomplish much more under this proposal than to put the euthanasia principle on the books?

Even if the patient's choice could be said to be "clear and incontrovertible," do not other difficulties remain? Is this the kind of choice, assuming that it can be made in a fixed and rational manner, that we want to offer a gravely ill person? Will we not sweep up, in the process, some who are not really tired of life, but think others are tired of them; some who do not really want to die, but who feel they should not live on, because to do so when there looms the legal alternative of euthanasia is to do a selfish or a cowardly act? Will not some feel an obligation to have themselves "eliminated" in order that funds allocated for their terminal care might be better used by their families or, financial worries aside, in order to relieve their families of the emotional strain involved?

It would not be surprising for the gravely ill person to seek to inquire of those close to him whether he should avail himself of the legal alternative of euthanasia. Certainly, he is likely to wonder about their attitude in the matter. It is quite possible, is it not, that he will not exactly be gratified by any inclination on their part — however noble their motives may be in fact — that he resort to the new procedure? At this stage, the patient-family relationship may well be a good deal less than it ought to be:

Illness, pain and fear of death tend to activate the dependent longings [for the family unit]. Conflict can easily arise, since it may be very difficult for the individual to satisfy his need for these passive dependent needs and his previous concept of the necessity for a competitive, constructive individuality. Our culture provides few defenses for this type of stress beyond a suppression of the need. If the individual's defenses break down, he may feel angry toward himself and toward the members of his family.⁵⁷

And what of the relatives? If their views will not always influence the patient, will they not at least influence the attending physician? Will a physician assume the risks to his reputation, if not his pocketbook, by administering the *coup de grace* over the

57. Zarling, *supra* note 45, at 215.

objection — however irrational — of a close relative?⁵⁸ Do not the relatives, then, also have a "choice?" Is not the decision on their part to do nothing and say nothing *itself* a "choice?"⁵⁹ In many families there will be some, will there not, who will consider a stand against euthanasia the only proof of love, devotion and gratitude for past events? What of the stress and strife if close relatives differ — as they did in the famous *Sander* case⁶⁰ — over the desirability of euthanatizing the patient?

At such a time, as the well-known *Paight* case clearly demonstrates,⁶¹ members of the family are not likely to be in the best state of mind, either, to make this kind of decision. Financial stress and conscious or unconscious competition for the family's estate aside:

The chronic illness and persistent pain in terminal carcinoma may place strong and excessive stresses upon the family's emotional ties with the patient. The family members who have strong emotional attachment to start with are most likely to take the patient's fears, pains and fate personally. Panic often strikes them. Whatever guilt feelings they may have toward the patient emerge to plague them.

If the patient is maintained at home, many frustrations and physical demands may be imposed on the family by the advanced illness. There may develop extreme weakness, incontinence and bad odors. The pressure of caring for the individual under these

58. The medical profession is apparently already quite sensitive about the "sue consciousness" on the part of the public. See Caswell, *A Surgeon's Thoughts on Malpractice*, 30 Temple L.Q. 391 (1957) (symposium). There is good reason to think that "the greater incidence of suits and claims against physicians alleging medical malpractice and a greater financial success in prosecuting these" has led to "insecurity" on the part of many physicians, and "the insecure physician is going to play it safe." Wachowski and Stronach, *The Radiologist and Professional Medical Liability*, 30 Temple L.Q. 398 (1957). Apparently, in some fields fear of claims and litigation has already set "the psychological stage for undertreatment." *Id.* at 399.

59. Cf. the examination of Sir Harold Scott, Commissioner of Police of the Metropolis by the Royal Commission on Capital Punishment, Minutes of Evidence 151 (Oct. 7, 1949):

1599. Nobody at present, except the law, has to decide that a particular person should be sentenced to death, no individual?—No individual at present, except the Home Secretary, has to decide that a particular person sentenced to death must hang.

1600. The Home Secretary is in a different position, is he not? He does not primarily prescribe the death penalty; the law does that. The Home Secretary says whether or not he deems it right to interfere with the course of the law?—Yes, that is the legal position. It is a different position, technically, but it seems to me that morally there really is no difference. The responsibility upon the Home Secretary is really to decide whether this man shall die or not die. The machinery may be by interference or non-interference with the law, but the responsibility to me seems the same.

60. See note 172, *infra*. See also the *Mohr* case; *supra* note 17, where two brothers testified against a third who had euthanatized a fourth.

61. See note 176, *infra*.

circumstances is likely to arouse a resentment and, in turn, guilt feelings on the part of those who have to do the nursing.⁶²

Nor should it be overlooked that while Professor Williams would remove the various procedural steps and the various personnel contemplated in the American and English Bills and bank his all on the "good sense" of the general practitioner, no man is immune to the fear, anxieties and frustrations engendered by the apparently helpless, hopeless patient. Not even the general practitioner:

Working with a patient suffering from a malignancy causes special problems for the physician. First of all, the patient with a malignancy is most likely to engender anxiety concerning death, even in the doctor. And at the same time, this type of patient constitutes a serious threat or frustration to medical ambition. As a result, a doctor may react more emotionally and less objectively than in any other area of medical practice. . . . His deep concern may make him more pessimistic than is necessary. As a result of the feeling of frustration in his wish to help, the doctor may have moments of annoyance with the patient. He may even feel almost inclined to want to avoid this type of patient.⁶³

The only Anglo-American prosecution involving an alleged mercy-killing physician seems to be the case of Dr. Herman Sander. The state's testimony was to the effect that, as Sander had admitted on various occasions, he finally yielded to the persistent pleas of his patient's husband and pumped air into her veins "in a weak moment."⁶⁴ Sander's version was that he finally "snapped" under the strain of caring for the cancer victim,⁶⁵ bungled simple tasks,⁶⁶ and became "obsessed" with the need to "do something" for her — if

62. Zarling, *supra*, note 45 at 211-12.

63. *Id.* at 213-14. See also Dr. Benjamin Miller to the effect that cancer "can be a 'horrible experience' for the doctor too" and that "a long difficult illness may emotionally exhaust the relatives and physician even more than the patient." Miller, *supra* note 50, at 103; and Stephen, *Murder from the Best of Motives*, 5 L.Q. Rev. 188 (1889), commenting on the disclosure by a Dr. Thwing that he had practiced euthanasia: "The boldness of this avowal is made particularly conspicuous by Dr. Thwing's express admission that the only person for whom the lady's death, if she had been allowed to die naturally, would have been in any degree painful was not the lady herself, but Dr. Thwing."

64. N.Y. Times, Feb. 24, 1950, p. 1, col. 6.

65. "As I looked at her face and all of the thoughts of the past went through my mind, something snapped in me, and I felt impelled or possessed to do something, and why I did it, I can't tell. It doesn't make sense." N.Y. Times, March 7, 1950, p. 19, col. 1.

66. "I didn't use a tourniquet, which is also rather a ridiculous thing, because ordinarily in a normal patient we put on a tourniquet to bring up the vein so that we can see it. Her veins were collapsed anyhow and I couldn't have been thinking the way I ordinarily do at the time. Otherwise I wouldn't have acted this way." *Ibid.*

only to inject air into her *already* dead body.⁶⁷ Whichever side one believes — and the jury evidently believed Dr. Sander⁶⁸ — the case well demonstrates that at the moment of decision the tired practitioner's "good sense" may not be as good as it might be.

Putting aside the problem of whether the good sense of the general practitioner warrants dispensing with other personnel, there still remains the problems posed by *any* voluntary euthanasia program: the aforementioned considerable pressures on the patient and his family. Are these the kind of pressures we want to inflict on any person, let alone a very sick person? Are these the kind of pressures we want to impose on any family, let alone an emotionally-shattered family? And if so, why are they not also proper considerations for the crippled, the paralyzed, the quadruple amputee, the iron lung occupant and their families?

Might it not be said of the existing ban on euthanasia, as Professor Herbert Wechsler has said of the criminal law in another connection:

It also operates, and perhaps more significantly, at anterior stages in the patterns of conduct, the dark shadow of organized disapproval eliminating from the ambit of consideration alternatives that might otherwise present themselves in the final competition of choice.⁶⁹

C. The "Hopelessly Incurable" Patient and the Fallible Doctor.

Professor Williams notes as "standard argument" the plea that "no sufferer from an apparently fatal illness should be deprived of his life because there is always the possibility that the diagnosis is wrong, or else that some remarkable cure will be discovered in time."⁷⁰ But he does not reach the issue until he has already dismissed it with this prefatory remark:

67. "[J]ust the appearance of her face and the combination of all the thoughts of her long suffering and of her husband's suffering also—this expression on her face might have just touched me off and made me feel obsessed that I had to do something and what I did does not make sense." *Ibid.*

68. See note 172 *infra*, and accompanying text.

69. Wechsler, *The Issues of the Nuremberg Trial*, 62 Pol. Sci. Q. 11, 16 (1947). Cf. Cardozo, *What Medicine Can Do for Law*, in *Law and Literature* 88-89 (1931):

Punishment is necessary, indeed, not only to deter the man who is a criminal at heart, who has felt the criminal impulse, who is on the brink of indecision, but also to deter others who in our existing social organization have never felt the criminal impulse and shrink from crime in horror. Most of us have such a scorn and loathing of robbery or forgery that the temptation to rob or forge is never within the range of choice; it is never a real alternative. There can be little doubt, however, that some of this repugnance is due to the ignominy that has been attached to these and like offenses through the sanctions of the criminal law. If the ignominy were withdrawn, the horror might be dimmed.

70. Williams, p. 318.

It has been noticed before in this work that writers who object to a practice for theological reasons frequently try to support their condemnation on medical grounds. With euthanasia this is difficult, but the effort is made.⁷¹

Does not Williams, while he pleads that euthanasia not be theologically prejudged, at the same time invite the inference that non-theological objections to euthanasia are simply camouflage?

It is no doubt true that many theological opponents employ medical arguments as well, but it is also true that the doctor who has probably most forcefully advanced medical objections to euthanasia of the so-called incurables, Cornell University's world-renowned Foster Kennedy, a former president of the Euthanasia Society of America, *advocates* euthanasia in other areas where error in diagnosis and prospect of new relief or cures are much reduced, *i.e.*, the "congenitally unfit".⁷² In large part for the same reasons, Great Britain's Dr. A. Leslie Banks, then Principal Medical Officer of the Ministry of Health, maintained that a better case could be made for the destruction of congenital idiots and those in the final stages of dementia, particularly senile dementia, than could be made for the doing away of the pain-stricken incurable.⁷³

71. *Id.* at 317-18.

72. "What to do with the hopelessly unfit? I had thought at a younger time of my life that the legalizing of euthanasia—a soft gentle-sounding word—was a thing to be encouraged; but as I pondered, and as my experience in medicine grew, I became less sure. Now my face is set against the legalization of euthanasia for any person, who, having been well, has at last become ill, for however ill they be, many get well and help the world for years after. But I *am* in favor of euthanasia for those hopeless ones who should never have been born—Nature's mistakes. In this category it is, with care and knowledge, impossible to be mistaken in either diagnosis or prognosis." Kennedy, *The Problem of Social Control of the Congenital Defective*, 99 Am. J. Psychiatry, 13, 14 (1942).

"We doctors do not always know when a disease in a previously healthy person has become entirely incurable. But there are thousands and tens of thousands of the congenitally unfit, about whom no diagnostic error would be possible. . . . with nature's mistakes . . . there can be, after five years . . . of life, no error in diagnosis, nor any hope of betterment." Kennedy, *Euthanasia: To Be or Not To Be*, Colliers, May 20, 1939, pp. 15, 58; reprinted in Colliers, April 22, 1950, pp. 13, 51.

At the February, 1939, meeting of the Society of Medical Jurisprudence, Charles E. Nixdorff, treasurer and board chairman of the Euthanasia Society of America stated that the case of a 19-year-old girl in Bellevue, with a broken back and paralyzed legs, who "prayed for death every night" was sufficient reason for the Euthanasia Society "to carry on the fight." "Dr. [Foster] Kennedy [then President of the Euthanasia Society], in conversation, said later he did not think that was a particularly good example. He said he had known many such cases where the patients 'got around' and only recently he had 'danced with one.'" N.Y. Times, Feb. 14, 1939, p. 2, col. 6.

73. Banks, *Euthanasia*, 161 Practitioner 101, 106 (1948). According to him, neither "pain" nor "incurability" "is capable of precise and final definition, and indeed if each case had to be argued in open court there would be conflict of medical opinion in practically every instance." *Id.* at 104.

Surely, such opponents of voluntary euthanasia cannot be accused of wrapping theological objections in medical dressing!

Until the euthanasia societies of England and America had been organized and a party decision reached, shall we say, to advocate euthanasia only for incurables on their request, Dr. Abraham L. Wolbarst, one of the most ardent supporters of the movement, was less troubled about putting away "insane or defective people [who] have suffered mental incapacity and tortures of the mind for many years" than he was about the "incurables".⁷⁴ He recognized the "difficulty involved in the decision as to incurability" as one of the "doubtful aspects of euthanasia."

Doctors are only human beings, with few if any supermen among them. They make honest mistakes, like other men, because of the limitations of the human mind.⁷⁵

He noted further that "it goes without saying that, in recently developed cases with a possibility of cure, euthanasia should not even be considered," that "the law might establish a limit of, say, ten years in which there is a chance of the patient's recovery."⁷⁶

Dr. Benjamin Miller is another who is unlikely to harbor an ulterior theological motive. His interest is more personal. He himself was left to die the death of a "hopeless" tuberculosis victim only to discover that he was suffering from a rare malady which affects the lungs in much the same manner but seldom kills. Five years and sixteen hospitalizations later, Dr. Miller dramatized his point by recalling the last diagnostic clinic of the brilliant Richard Cabot, on the occasion of his official retirement:

He was given the case records [complete medical histories and results of careful examinations] of two patients and asked to diagnose their illnesses. . . . The patients had died and only the hospital pathologist knew the exact diagnosis beyond doubt, for he had seen the descriptions of the postmortem findings. Dr. Cabot, usually very accurate in his diagnosis, that day missed both.

The chief pathologist who had selected the cases was a wise person. He had purposely chosen two of the most deceptive to remind the medical students and young physicians that even at the end of a long and rich experience one of the greatest diagnosticians of our time was still not infallible.⁷⁷

74. Wolbarst, *Legalize Euthanasia*, 94 *The Forum* 330, 332 (1935). But see Wolbarst, *The Doctor Looks at Euthanasia*, 149 *Medical Record*, 354 (1939).

75. Wolbarst, *Legalize Euthanasia*, 94 *The Forum* 330, 331 (1935).

76. *Id.* at 332.

77. Miller, *supra* note 50, at 39.

Richard Cabot was the John W. Davis, the John Lord O'Brian, of his profession. When one reads the account of his last clinic, one cannot help but think of how fallible the *average* general practitioner must be, how fallible the *young doctor just starting practice* must be—and this, of course, is all that some small communities have in the way of medical care—how fallible the *worst* practitioner, young or old, must be. If the range of skill and judgment among licensed physicians approaches the wide gap between the very best and the very worst members of the bar—and I have no reason to think it does not—then the minimally competent physician is hardly the man to be given the responsibility for ending another's life.⁷⁸ Yet, under Williams' proposal at least, the marginal physician, as well as his more distinguished brethren, would have legal authorization to make just such decisions. Under Williams' proposal, euthanatizing a patient or two would all be part of the routine day's work.⁷⁹

Perhaps it is not amiss to add as a final note, that no less a euthanasiast than Dr. C. Killick Millard⁸⁰ had such little faith in the average general practitioner that as regards the *mere administering of the coup de grace*, he observed:

In order to prevent any likelihood of bungling, it would be very necessary that only medical practitioners who had been specially licensed to euthanise (after acquiring special knowledge and skill) should be allowed to administer euthanasia. Quite possibly, the work would largely be left in the hands of the official euthanisors, who would have to be appointed specially for each area.⁸¹

True, the percentage of correct diagnosis is particularly high in cancer.⁸² The short answer, however, is that euthanasiasts most emphatically do not propose to restrict mercy-killing to cancer cases. Dr. Millard has maintained that "there are very many diseases be-

78. As to how bad the bad physician can be, see generally, even with a grain of salt, 3 Belli, *Modern Trials* §§ 327-353 (1954). See also Regan, *Doctor and Patient and the Law* 17-40 (3d ed. 1956).

79. See note 41 *supra*, and accompanying text.

80. As Williams points out, p. 330, Dr. Millard introduced the topic of euthanasia into public debate in 1932 when he advocated that mercy-killing should be legalized in his presidential address to the Society of Medical Officers of Health. In moving the second reading of the voluntary euthanasia bill, Lord Ponsonby stated that "the movement in favour of drafting a Bill" had "originated" with Dr. Millard. 103 H.L. Deb. 466-67 (1936).

81. Millard, *The Case For Euthanasia*, 136 *Fortnightly Review* 701, 717 (1931). Under his proposed safeguards (two independent doctors, followed by a "medical referee") Dr. Millard viewed error in diagnosis as a non-detractable "remote possibility." *Ibid.*

82. Euthanasia opponents readily admit this. See e.g., Miller, *supra* note 50, at 38.

sides cancer which tend to kill 'by inches', and where death, when it does at last come to the rescue, is brought about by pain and exhaustion."⁸³ Furthermore, even if mercy-killings were to be limited to cancer, however relatively accurate the diagnosis in these cases, here, too, "incurability of a disease is never more than an estimate based upon experience, and how fallacious experience may be in medicine only those who have had a great deal of experience fully realize."⁸⁴

Dr. Daniel Laszlo, Chief of Division of Neoplastic Diseases, Montefiore Hospital, New York City, and three other physicians have observed:

The mass crowding of a group of patients labeled 'terminal' in institutions designated for that kind of care carries a grave danger. The experience gathered from this group makes it seem reasonable to conclude that a fresh evaluation of any large group in mental institutions, in institutions for chronic care, or in homes for the incurably sick, would unearth a rewarding number of salvageable patients who can be returned to their normal place in society. . . . For purposes of this study we were especially interested in those with a diagnosis of advanced cancer. In a number of these patients, major errors in diagnosis or management were encountered.⁸⁵

The authors then discuss in considerable detail the case histories of eleven patients admitted or transferred to Montefiore Hospital alone with the diagnosis of "*advanced cancer in its terminal stage*," none of whom had cancer at all. In three cases the organ suspected to be the primary site of malignancy was unaffected; in the other eight cases it was the site of some nonmalignant disease. The impact of these findings may be gleaned from a subsequent comment by Doctors Laszlo and Spencer: "Such cases [of mistaken diagnosis of advanced cancer] are encountered even in large medical centers and probably many more could be found in areas poorly provided with medical facilities."⁸⁶

Only recently, Dr. R. Ger, citing case histories of false cancer

83. Millard, *supra* note 81, at 702.

84. Frohman, *Vexing Problems in Forensic Medicine: A Physician's View*, 31 N.Y.U.L. Rev. 1215, 1216 (1956). Dr. Frohman added:

We practice our art with the tools and information yielded by laboratory and research scientists, but an ill patient is not subject to experimental control, nor are his reactions always predictable. A good physician employs his scientific tools whenever they are useful, but many are the times when intuition, chance, and faith are his most successful techniques.

85. Laszlo, *et. al.*, *Errors In Diagnosis And Management Of Cancer*, 33 *Annals Int. Med.* 670 (1950).

86. Laszlo and Spencer, *Medical Problems In The Management Of Cancer*, 37 *Med. Clin. N.A.* 869, 873 (1953).

diagnoses to buttress his point, had occasion to warn his colleagues:

Students are often told, and one is exhorted repeatedly in textbooks to do so, to regard signs and symptoms appearing over the age of 40 years as due to carcinoma [malignant epithelial tumor] until proved otherwise. While it is true that carcinoma should take first place on grounds of commonness, it must not be forgotten that there are other conditions which may mimic carcinoma clinically, radiologically and at operation, and which are essentially benign. There is danger, moreover, when presented with a case simulating carcinoma to assume it to be carcinoma without proving or disproving the diagnosis. This may give rise to unnecessary fatalities by either denying treatment because of a hopeless prognosis or carrying out unnecessary procedures.⁸⁷

Even more recently, Doctors De Vet and Walder scored the "extremely dangerous" tendency on the part of general practitioners and specialists alike "when a neoplasm becomes manifest in a patient previously operated on for a malignant tumour . . . to presume that the new growth is a metastasis [a transfer of the malignant disease]."⁸⁸ Their studies demonstrated that it is "by no means a rare occurrence" for patients to develop "another, benign tumour after having been operated upon for a malignant one."⁸⁹ De Vet and Walder also stress the "remarkable similarity" in symptoms, including "violent pain" in both cases, between metastases and benign processes of the spinal column and the spinal cord.⁹⁰

Faulty diagnosis is only one ground for error. Even if the diagnosis is correct, a second ground for error lies in the possibility that some measure of relief, if not a full cure, may come to the fore within the life expectancy of the patient. Since Glanville Williams does not deign this objection to euthanasia worth more than a pass-

87. Ger, *Diagnosis and Misdiagnosis of Carcinoma*, 28 So. Afr. Med. J. 670 (1954).

88. De Vet and Walder, *Pseudo-Metastases*, 7 Archivium Chirurgicum Neerlandicum 78 (1955).

89. *Id.* at 83.

90. *Id.* at 82. Consider also the following: At the 1951 annual meeting of the American Cancer Society, devoted to cytologic diagnosis of cancer, Dr. Henry M. Lemon noted: *Proceedings, Symposium on Exfoliative Cytology* at 106 (Oct. 23-24, 1951):

The problem of false positive diagnoses has always been a difficult one. About 5 per cent of the 541 non-cancer patients in whom cancer secretions have been studied in the past had false positive diagnosis made, and in our experience, gastritis has been a common cause of false positive diagnosis.

At the same meeting, Dr. William A. Cooper told of "fifteen misses" in X-ray gastric cancer diagnosis out of one hundred cases (*id.* at 102):

Four of the twenty-five cases of cancer were said to have benign lesions, while eleven of the seventy-five benign lesions were said to have cancer.

ing reference,⁹¹ it is necessary to turn elsewhere to ascertain how it has been met.

One answer is:

It must be little comfort to a man slowly coming apart from multiple sclerosis to think that, fifteen years from now, death might not be his only hope.⁹²

To state the problem this way is of course, to avoid it entirely. How do we know that fifteen *days* or fifteen *hours* from now, "death might not be [the incurable's] only hope?"

A second answer is:

[N]o cure for cancer which might be found 'tomorrow' would be of any value to a man or woman 'so far advanced in cancerous toxemia as to be an applicant for euthanasia'.⁹³

As I shall endeavor to show, this approach is a good deal easier to formulate than it is to apply. For one thing, it presumes that we know today *what* cures will be found tomorrow. For another, it overlooks that if such cases can be said to exist, the patient is likely to be *so far* advanced in cancerous toxemia as to be no longer capable of understanding the step he is taking and hence *beyond* the stage when euthanasia ought to be administered.⁹⁴

A generation ago, Dr. Haven Emerson, then President of the American Public Health Association, made the point that "no one can say today what will be incurable tomorrow. No one can predict what disease will be fatal or permanently incurable until medicine becomes stationary and sterile." Dr. Emerson went so far as to say that "to be at all accurate we must drop altogether the term 'in-

91. See Williams, p. 318.

92. *Pro & Con: Shall We Legalize "Mercy Killing"?*, Readers Digest, Nov. 1938, pp. 94, 96.

93. James, *Euthanasia—Right or Wrong?*, Survey Graphic, May, 1948, pp. 241, 243; Wolbarst, *The Doctor Looks at Euthanasia*, 149 Medical Record, 354, 355 (1939).

94. Thus, Doctor Millard, in his leading article, *supra* note 81, at 710, states:

A patient who is too ill to understand the significance of the step he is taking has got beyond the stage when euthanasia ought to be administered. In any case his sufferings are probably nearly over.

Glanville Williams similarly observes (pp. 342-44):

Under the bill as I have proposed to word it, the consent of the patient would be required, whereas it seems that some doctors are now accustomed to give fatal doses without consulting the patient. I take it to be clear that no legislative sanction can be accorded to this practice, in so far as the course of the disease is deliberately anticipated. The essence of the measures proposed by the two societies is that euthanasia should be voluntarily accepted by the patient.

... The measure here proposed is designed to meet the situation where the patient's consent to euthanasia is clear and incontrovertible.

curables' and substitute for it some such term as 'chronic illness'.⁹⁵

That was a generation ago. Dr. Emerson did not have to go back more than a decade to document his contention. Before Banting and Best's insulin discovery, many a diabetic had been doomed. Before the Whipple-Minot-Murphy liver treatment made it a relatively minor malady, many a pernicious anemia sufferer had been branded "hopeless." Before the uses of sulfanilimide were disclosed, a patient with widespread streptococcal blood poisoning was a condemned man.⁹⁶

Today, we may take even that most resolute disease, cancer, and we need look back no further than the last decade of research in this field to document the same contention.⁹⁷

Three years ago, Dr. William D. McCarthy presented the results to date, of an effort begun in 1950 to open a new approach in cancer palliation,⁹⁸ a report whose findings of "remarkable improvement" in nearly a third of the cases invoked strong editorial comment in the *New England Journal of Medicine*.⁹⁹ At the time of Dr. McCarthy's report, 100 "hopeless" patients with a wide variety of neoplasms had been treated with a combination of nitrogen mustard and ACTH or cortisone. "All patients in the series were in advanced or terminal phases of disease, and were accepted for treatment only after the disease was determined to be progressive after adequate surgery or radiation therapy."¹⁰⁰ Dr. McCarthy summarizes the results:

In several of these cases there was associated tumor regression or arrest, with definite prolongation of life in increased comfort. This group constituted 15 per cent of the series. Reserved for the classification as excellent response were 16 additional patients (16 per cent) whose subjective and objective remissions were striking, often accompanied with tumor regression or arrest, and whose improvement persisted for six months or longer. These patients represent the true temporary remissions of the series. They are, however, temporary remissions and not

95. Emerson, *Who Is Incurable? A Query and Reply*, N.Y. Times, Oct. 22, 1933, § 8, p. 5, col. 1.

96. *Ibid.*, Miller, *supra* note 50, at 39.

97. This is not to say that progress in the treatment of cancer cases has been limited to the last decade. Over twenty years ago, Lord Horder, 103 H.L. Deb. 466, 492 (1936), opposing the euthanasia bill in the House of Lords debates, observed:

[A]lthough it is common knowledge that the essential causative factors of cancer still elude us, there are patients to-day suffering from this disease, not only living but free from pain, who would not have been living ten years ago, and this as the result of advances made in treatment.

98. McCarthy, *The Palliation and Remission of Cancer With Combined Corticosteroid and Nitrogen Mustard Therapy*, 252 N. Eng. J. Med. 467 (1955).

99. *Treatment of Advanced Cancer*, 252 N. Eng. J. Med. 502 (1955).

100. McCarthy, *supra* note 98 at 468.

permanent remissions or so called 'cures.' Nevertheless, as a group originally considered hopeless, each has been afforded longer life, acceptable health and freedom from pain. Fortunately, prolongation of life appeared to occur only in patients who received good palliation. . . .

Unusual temporary remissions for intervals as long as three years were obtained. . . .¹⁰¹

Needless to say, a number of those who received substantial benefits from this particular therapy were suffering from great pain and appeared to be leading candidates for voluntary euthanasia. In 1950, the year the new combination therapy investigation was initiated, a swift death appeared to be their only hope. Instead they resumed full and useful lives for a considerable period of time.¹⁰²

Since February, 1951, in a new effort to inhibit certain cancer growth,¹⁰³ a number of advanced cancer patients at the Memorial Center for Cancer and Allied Disease have had their adrenal glands removed.¹⁰⁴ Of a total of ten patients with cancer of the prostate adrenalectomized at the time of the 1952 report, three died in the immediate postoperative period of various causes, leaving seven

101. *Id.* at 470, 475. Some of the results were little short of spectacular. See e.g., Case 1, *id.* at 470, the case of a woman whose reticulum-cell sarcoma "was considered too disseminated for radiation therapy" who responded so well to therapy that she returned to employment as a nurse for three years; Case 3, *ibid.*, that of a man taken to the hospital "in a terminal state" with "a massive lymphosarcoma of the pelvis" which had received X-ray therapy and which was increasing rapidly in size, who returned to his occupation and but for a short interval when he underwent a second course of therapy "continued working up to the time of his death . . . eighteen months after the 1st course of combination therapy"; Case 11, *id.* at 472-73, that of a stomach-cancer victim "in a terminal condition, unable to retain solids or fluids" who, after three months of the therapy, regained her normal weight, returned to her occupation and enjoyed excellent health for a full year.

On the other hand, some 40 per cent of the group were considered failures (those who died within a month and those who survived longer but received little benefit); 29 per cent were classed as fair in response (moderate but brief palliation). *Id.* at 470.

102. See also Ravich, *Euthanasia and Pain In Cancer*, 9 *Unio Internationalis Contra Cancrum* 397 (1953), a report of the promising experimental chemotherapeutic measures (*n*-Butanol, glycerine and sodium thiolsulfate) of Dr. Emanuel Revici and the staff of the Institute of Applied Biology. A number of patients whose cancers "had advanced beyond the point where any help was to be anticipated from surgery, X-ray or radium, according to the opinions of the attending physicians," *id.* at 398, returned to their normal occupations after the onset of treatment and remained on the job for several years.

103. Drs. Huggins and Scott had reported the first total bilateral adrenalectomies in patients with prostatic carcinoma in 1945, but since cortisone was not then available all patients died in adrenal insufficiency. The authors therefore concluded at that time that the operation was not practical and temporarily abandoned this approach. See Huggins and Scott, *Bilateral Adrenalectomy In Prostatic Cancer: Clinical Features and Urinary Excretion of 17 Ketosteroids and Estrogen*, 122 *Annals of Surgery* 1031 (1945).

104. West, et. al., *The Effect of Bilateral Adrenalectomy Upon Neoplastic Disease in Man*, 5 *Cancer* 1009 (1952).

effective cases for evaluation :

The most striking beneficial response to adrenalectomy was relief of pain. Three of the patients were confined to bed with pain prior to surgery and were taking narcotics frequently. . . . All three had striking relief of pain postoperatively and became ambulatory. One (J.W.) was in a stuporous condition pre-operatively, confined to bed, and unable to feed himself. Following adrenalectomy his general condition improved remarkably. He became ambulatory and was able to return home to live a relatively normal life. This improvement has been maintained until the present, 218 days after surgery. . . .

Summarizing the prostatic cancer cases, all seven effective cases had striking subjective improvement. Only two cases showed objective improvement. Improvement was temporary in all cases.¹⁰⁵

From all indications "J.W." was a most attractive target for the euthanasiasts. He was suffering from "severe pain requiring frequent injections of narcotics for relief . . . was extremely lethargic and relatively unresponsive . . . had to be fed by the nursing staff."¹⁰⁶ If he, to use Dr. Wolbarst's words, was not "so far advanced in cancerous toxemia as to be an applicant for euthanasia," when will anybody be? I am not at all sure that at this point J.W. was still *capable* of consenting to his death. If he were, he certainly had reached the very brink. As it turned out, however, to have put J.W. out of his misery at the time would have been to deprive him of over seven months of a "relatively normal life."¹⁰⁷ Adequate quantities of cortisone and other active corticoids had just become available. The postoperative problem of adrenal insufficiency had just been solved.

Breast cancer, the most common cancer in woman,¹⁰⁸ has also yielded substantially to adrenalectomy. A recent five-year evaluation of 52 consecutive patients with metastatic mammary cancer who underwent adrenalectomy disclosed that significant objective

105. *Id.* at 1012-13. Dr. M. P. Reiser of the University of Minnesota Medical School and his colleagues have planted radon-filled seeds of gold into the prostate area in an effort to save patients with "inoperable" cancer of the prostate gland. As a result, thirteen of twenty-five patients have lived at least a year; six have lived from three to seven years. Radon is the gas of radium. See Cohn, *'U' Reports Victories Over Cancer*, Minneapolis Morning Tribune, April 4, 1958, p. 13, col. 4.

106. West, *supra* note 104 at 1010.

107. An addendum to the report discloses that J.W.'s post-operative "subjective improvement" lasted 220 days and that he survived for 294 days, *id.* at 1016-17. What pain J. W. suffered in his last days is not revealed, but in general discussion the authors state that ". . . [I]n the majority of the cases, the pain never did return to its preoperative intensity even though the patient later died of cancer." *Id.* at 1015.

108. American Cancer Society, *1958 Cancer Facts and Figures* 17.

remissions of varying lengths of time occurred in 20 patients.¹⁰⁹ Prolonged survival—from three years to 63 months—occurred in seven of these patients, all of whom had been suffering from advanced stages of the disease, had failed to respond to various other types of therapy and were incapacitated. After treatment, "all of them were able to resume their normal physical activities."¹¹⁰ One of the seven had had such extensive metastases that she "appeared to be moribund," but she survived, with great regression of the neoplasm, more than five years after adrenalectomy.¹¹¹

The pituitary gland, as well as the adrenal glands, has had an increasing apparent role in the control of breast cancer. Since 1951, the availability of ACTH and cortisone has allowed an intensive investigation of the effects of hypophysectomy, *i.e.*, surgical removal of the pituitary body. The results have been most gratifying. A recent report, for example, discloses that of twenty-eight patients with advanced breast cancer who underwent total hypophysectomy, "eighteen . . . have demonstrated striking objective clinical regressions" up to twenty months while an additional four who showed no objective evidence of regression experienced "striking relief of pain."¹¹²

The dynamic state of current cancer research would appear to be amply demonstrated by the indication, already, that in the treatment of advanced breast cancer, adrenalectomy, itself still in the infant stages, may yield to hypophysectomy.¹¹³

109. Dao and Huggins, *Metastatic Cancer of the Breast Treated by Adrenalectomy*, 165 A.M.A.J. 1793 (1957).

Furthermore, an additional nine patients who underwent no demonstrable regression experienced marked objective improvement in relief of bone pain, disappearance of respiratory symptoms and return of a sense of well-being. An earlier report on adrenalectomy disclosed that of five "effective" breast carcinoma cases, a sixth having died of other causes a short time after undergoing the operation, "all had severe pain preoperatively, and all had either partial or complete relief of pain following adrenalectomy." West, *supra* note 104, at 1014.

110. *Id.* at 1796.

111. *Ibid.*

112. Kennedy, French and Peyton, *Hypophysectomy in Advanced Breast Cancer*, 255 N. Eng. J. Med., 1165, 1171 (1956). See also Kennedy, *The Present Status of Hormone Therapy in Advanced Breast Cancer*, 69 Radiology 330, 333-34 (1957).

For earlier reports, see Luft and Olivecrona, *Hypophysectomy In Man: Experiences in Metastatic Cancer of the Breast*, 8 Cancer 261 (1955) (13 of 37 patients showed subjective or objective improvement for from 3 to 27 months); Pearson, *et. al.*, *Hypophysectomy in Treatment of Advanced Cancer*, A.M.A.J. 17 (1956) (over half of 41 patients who could be evaluated underwent objective remissions).

113. "In view of the favorable responses after hypophysectomy, the concomitant adrenal atrophy and the ease in managing the patient, it appears that hypophysectomy is to be preferred over adrenalectomy in the treatment of advanced breast cancer." Kennedy, French and Peyton, *supra* note 112, at 1171.

True, many types of cancer still run their course virtually unhampered by man's arduous efforts to inhibit them. But the number of cancers coming under some control is ever increasing. With medicine attacking on so many fronts with so many weapons who would bet a man's life on when and how the next type of cancer will yield, if only just a bit?¹¹⁴

True, we are not betting much of a life. For even in those areas where gains have been registered, the life is not "saved," death is only postponed. Of course, in a sense this is the case with every "cure" for every ailment. But it may be urged that after all there is a great deal of difference between the typical "cure" which achieves an indefinite postponement, more or less, and the cancer respite which results in only a brief intermission, so to speak, of rarely more than six months or a year. Is this really long enough to warrant all the bother?

Well, how long is long enough? In many recent cases of cancer respite, the patient, though experiencing only temporary relief, underwent sufficient improvement to retake his place in society.¹¹⁵ Six or twelve or eighteen months is long enough to do most of the

114. In addition to the various approaches to the cancer problem discussed *supra*, consider, *e.g.*, the following items which have appeared in the daily newspapers the past few months:

(1). In April of 1958, scientists uncovered a new chemical compound—fluorine combined with a body compound used by cancer cells for growth—which inhibits the growth of cancer cells. The discovery was hailed as a major step in the search for a medical "magic bullet" which can kill cancer cells outright. New York Times, April 4, 1958, p. 23, col. 7; Minneapolis Morning Tribune, April 4, 1958, p. 14, col. 5.

(2). Neutron radiation on brain cancer patients has led to "significant" increases in length of life, according to Dr. William H. Sweet of the Harvard Medical School. This September, Dr. Sweet will use an atomic reactor in an unprecedented effort to remove all remnants of brain cancer from a patient. Cohn, *Brain Cancer Surgeons Will Use Atomic Reactor*, Minneapolis Morning Tribune, March 30, 1958, p. 1, col. 1.

(3). There is reason to think that neurosonic surgery, sound waves focussed on precise spots inside the brain, may prove valuable in treating brain cancers—with a dosage devised to kill only cancer cells. Palsy victims for as long as 35 years have been relieved by such treatment. New York Times, April 2, p. 33, col. 8; Minneapolis Morning Tribune, April 2, 1958, p. 8, col. 5.

(4). Dr. Roy Hertz, an expert of the National Cancer Institute, has disclosed that a drug called methotrexate has suppressed all evidence of a type of cancer occurring in woman during pregnancy, but the "full value of the treatment remains to be determined." New York Times, Feb. 29, 1958, p. 62, col. 4.

(5). Dr. L. M. Tocantins of Jefferson Medical College has been conducting experiments to combat leukemia with whole-body X-ray doses calculated to kill the sick bone marrow cells that are producing the illness. Good marrow, taken from the bones of volunteers, is then injected into the patients. Such a technique has reversed leukemia's course in mice and given some of them normal life spans. Cohn, *They Give Ribs to Fight Leukemia*, Minneapolis Morning Tribune, March 26, 1958, p. 1, col. 4.

115. See notes 101, 102, 105, 109 *supra*.

things which socially justify our existence, is it not? Long enough for a nurse to care for more patients, a teacher to impart learning to more classes, a judge to write a great opinion, a novelist to write a stimulating book, a scientist to make an important discovery and, after all, for a factory hand to put the wheels on another year's Cadillac.

D. *"Mistakes Are Always Possible"*.

Under Professor Williams' "legislative suggestion" a doctor could "refrain from taking steps to prolong the patient's life by medical means" solely on his own authority. Only when disposition by affirmative "mercy-killing" is a considered alternative need he do so much as, and only so much as, consult another general practitioner.¹¹⁶ There are no other safeguards. No "euthanasia referee," no requirement that death be administered in the presence of an official witness, as in the English society's bill. No court to petition, no committee to investigate and report back to the court, as in the American society's bill. Professor Williams' view is:

It may be allowed that mistakes are always possible, but this is so in any of the affairs of life. And it is just as possible to make a mistake by doing nothing as by acting. All that can be expected of any moral agent is that he should do his best on the facts as they appear to him.¹¹⁷

That mistakes are always possible, that mistakes are always made, does not, it is true, deter society from pursuing a particular line of conduct—if the line of conduct is *compelled* by needs which override the risk of mistake. A thousand *Convicting the Innocent's*¹¹⁸ or *Not Guilty's*¹¹⁹ may stir us, may spur us to improve the administration of the criminal law, but they cannot and should not bring the business of deterring and incapacitating dangerous criminals or would-be dangerous criminals to an abrupt and complete halt.

Professor Williams points to capital punishment, as proponents of euthanasia are fond of doing,¹²⁰ but defenders of this practice do not—as, of course, they cannot—rest on the negative argument that "mistakes are always possible." Rightly or wrongly,

116. For a discussion of the legal significance of "mercy-killing" by omission and Williams' consultation feature for affirmative "mercy-killing," see note 41 *supra*.

117. Williams, p. 318.

118. Borchard, *Convicting the Innocent* (1932).

119. Frank and Frank, *Not Guilty* (1957).

120. See, e.g., Fletcher, *Morals and Medicine*, 181, 195-96 (1954); Milard, *The Case For Euthanasia*, 136 *Fortnightly Review* 701, 717 (1931); Potter, *The Case for Euthanasia*, Reader's Scope, May 1947, pp. 111, 113.

they contend that the deterrent value of the death penalty so exceeds that of life-imprisonment or long-term imprisonment that it is required for the protection of society, that it results in the net gain of a substantial number of human lives.¹²¹ This is generally regarded as the "central" or "fundamental" question in considering whether the death penalty should be abolished or retained.¹²² This, as Viscount St. Davids said of a House of Lords debate on capital punishment which saw him advocate abolition, "was what the whole debate was about."¹²³

Presumably, when and if it can be established to the satisfaction of all reasonable men that the deterrent value of capital punishment as against imprisonment is nil or *de minimus*, mistakes will no longer be tolerated and the abolitionists will have prevailed over the few remaining retentionists who would still defend capital punishment on other grounds.¹²⁴ In any event, it is not exactly a show of strength for euthanasiaists to rely on so battered and shaky a practice as capital punishment.¹²⁵

121. See generally Royal Commission on Capital Punishment, Report, Cmd. No. 8932, paras. 55-68 (1949-53); Michael and Wechsler, *Criminal Law And Its Administration*, 235-62 (1940).

122. H. L. A. Hart, *Murder And The Principle Of Punishment: England And The United States*, 52 N.W. U. L. Rev. 433, 446, 455 (1957). See also, e.g., Bye, *Capital Punishment in the United States* 31 (1919); Gardiner, *Capital Punishment as a Deterrent: And the Alternative* 17, 22 (1956); Caldwell, *Why Is the Death Penalty Retained?* 284 *Annals Am. Acad. Pol. & Soc. Sci.* 45, 50 (1952).

123. "I believed that the figures showed that if you abolish capital punishment you do not, in fact, lose more human lives. Other noble Lords took the opposite view; they believed that if capital punishment were abolished we should lose more lives. Both sides, however, believed that there is an ultimate value in human life. That was what the whole debate was about." 169 H.L. Deb. (5th ser.) 551, 591 (1950).

124. The remaining pockets of resistance would be manned by those who would utilize the death penalty as an instrument of vengeance, as a device for placing a special stigma on certain crimes, and as a means of furnishing the criminal with an extraordinary opportunity to repent before execution. See the discussion in the Royal Commission Report, *supra* note 121, at paras. 52-54.

125. Books attacking the utilization of the death penalty include Bye, *Capital Punishment In the United States* (1919); Calvert, *Capital Punishment In The Twentieth Century* (4th ed. 1930); Frank and Frank, *Not Guilty* 248 (1957); Gardiner, *Capital Punishment As A Deterrent: And the Alternative* (1956); Koestler, *Reflections on Hanging* (1956); Lawes, *Twenty Thousand Years In Sing Sing*, 291-337 (1932); Weihs, *The Urge To Punish* 146-70 (1956).

In February, 1956, the House of Commons on a free vote of 292 to 246 passed a resolution calling for the abolition or suspension of the death penalty which stated in part that "the death penalty for murder no longer accords with the needs or true interests of a civilized society" 548 H.C. Deb. (5th ser.) 2556, 2652, 2655, (1956). The House of Lords, however, rejected the legislation passed in the spirit of this resolution. See H.L.A. Hart, *supra* note 122, at 434. Bertrand Russell recently commented (*supra* note 2, at 385):

I have not the relevant statistics, but I think if a poll had been taken [of the House of Lords in 1936] it would have been found that most of those who objected to euthanasia favoured capital punishment, the dominant

A relevant question, then, is what is the need for euthanasia which leads us to tolerate the mistakes, the very fatal mistakes, which will inevitably occur? What is the compelling force which requires us to tinker with deeply entrenched and almost universal¹²⁶ precepts of criminal law?

Let us first examine the qualitative need for euthanasia:

Proponents of euthanasia like to present for consideration the case of the surgical operation, particularly a highly dangerous one: risk of death is substantial, perhaps even more probable than not; in addition, there is always the risk that the doctors have misjudged the situation and that no operation was needed at all. Yet it is not unlawful to perform the operation.¹²⁷

The short answer is the witticism that whatever the incidence of death in connection with different types of operations "no doubt, it is in all cases below 100 per cent, which is the incidence rate for euthanasia."¹²⁸ But this may not be the full answer. There are occasions where the law permits action involving about a 100 per cent incidence of death, for example, self-defense. There may well be other instances where the law should condone such action, for example, the "necessity" cases illustrated by the overcrowded life-boat,¹²⁹ the starving survivors of a ship-wreck,¹³⁰ and—perhaps best of all—by Professor Lon Fuller's penetrating and fascinating tale of the trapped cave explorers.¹³¹

In all these situations, death for some may well be excused, if not justified, yet the prospect that some deaths will be unnecessary is a real one. He who kills in self-defense may have misjudged the facts. They who throw passengers overboard to lighten the load may no sooner do so than see "masts and sails of rescue . . . emerge out of the fog".¹³² But no human being will ever find himself in a situation where he knows for an absolute certainty that one

consideration in each case being faithfulness to tradition.

Perhaps, but I would speculate further that if such a poll had been taken, it may well have been found that most of those who *avored* euthanasia *objected* to capital punishment. And on such grounds as the irrevocability of the death sentence and the inevitable incident of error in the selection of its victims, the insufficient showing that such a drastic method is needed, and, perhaps, the sanctity of life.

126. See Silving, *supra* note 7.

127. See, e.g., Fletcher, *op. cit. supra* note 3, at 198; Euthanasia Society of America, *Merciful Release*, art. 7; Millard, *supra* note 81 at 717.

128. Rudd, *Euthanasia*, 14 J. Clin. & Exper. Psychopath. 1, 4 (1953).

129. See *United States v. Holmes*, 26 Fed. Cas. No. 15,383 (C.C.E.D. Pa. 1842).

130. See *Regina v. Dudley & Stephens*, 14 Q.E.D. 273 (1884).

131. Fuller, *The Case of the Speluncean Explorers*, 62 Harv. L. Rev. 616 (1949).

132. Cardozo, *What Medicine Can Do For Law*, in *Law and Literature* 113 (1931).

or several must die that he or others may live. "Modern legal systems . . . do not require divine knowledge of human beings."¹³³

Reasonable mistakes, then, may be tolerated if as in the above circumstances and as in the case of the surgical operation, these mistakes are the inevitable by-products of efforts to save one or more human lives.¹³⁴

The need the euthanasiaist advances, however, is a good deal less compelling. It is only to ease pain.

Let us next examine the quantitative need for euthanasia:

No figures are available, so far as I can determine, as to the number of say, cancer victims, who undergo intolerable or overwhelming pain. That an appreciable number do suffer such pain, I have no doubt. But that anything approaching this number whatever it is, need suffer such pain, I have—viewing the many sundry

133. Hall, *General Principles of Criminal Law*, 399 (1947). Cardozo, on the other hand, seems to say that absent such certainty it is wrong for those in a "necessity" situation to escape their plight by sacrificing any life. Cardozo, *supra* note 132, at 113. On this point, as on the whole question of "necessity," his reasoning, it is submitted, is paled by the careful and intensive analyses found in Hall, *supra*, at 377-426, and Williams, *op. cit. supra* note 4, at 577-586.

See also Cahn, *The Moral Decision* (1955). Although he takes the position that in the Holmes' situation, "if none sacrifice themselves of free will to spare the others—they must all wait and die together," Cahn rejects Cardozo's view as one which "seems to deny that we can ever reach enough certainty as to our factual beliefs to be morally justified in the action we take." *Id.* at 70-71.

Some time after this paper was in galley, Section 3.02 of the Model Penal Code (Tent. Draft No. 8, 1958) made its appearance. This section provides (unless the legislature has otherwise spoken) that certain "necessity" killings shall be deemed justifiable so long as the actor was not "reckless or negligent in bringing about the situation requiring a choice of evils or in appraising the necessity for his conduct." The section only applies to a situation where "the evil sought to be avoided by such conduct is greater than that sought to be prevented by the law," *e.g.*, killing one that several may live. The defense would not be available, *e.g.*, "to one who acted to save himself at the expense of another, as by seizing a raft when men are shipwrecked." *Comment* to Section 3.02, *id.* at 8. For "in all ordinary circumstances lives in being must be assumed . . . to be of equal value, equally deserving the protection of the law." *Ibid.*

134. Cf. Macauley, *Notes on the Indian Penal Code*, Note B, p. 131 (1851), reprinted in 7 *The Miscellaneous Works of Lord Macauley* 252 (Bibliophile ed.):

It is often the wisest thing that a man can do to expose his life to great hazard. It is often the greatest service that can be rendered to him to do what may very probably cause his death. He may labor under a cruel and wasting malady which is certain to shorten his life, and which renders his life, while it lasts, useless to others and a torment to himself. Suppose that under these circumstances he, undecieved, gives his free and intelligent consent to take the risk of an operation which in a large proportion of cases has proved fatal, but which is the only method by which his disease can possibly be cured, and which, if it succeeds, will restore him to health and vigor. We do not conceive that it would be expedient to punish the surgeon who should perform the operation, though by performing it he might cause death, not intending to cause death, but knowing himself to be likely to cause it.

palliative measures now available¹³⁵—considerable doubt. The whole field of severe pain and its management in the terminal stage of cancer is, according to an eminent physician, "a subject neglected far too much by the medical profession."¹³⁶ Other well-qualified commentators have recently noted the "obvious lack of interest in the literature about the problem of cancer pain"¹³⁷ and have scored "the deplorable attitude of defeatism and therapeutic inactivity found in some quarters."¹³⁸

The picture of the advanced cancer victim beyond the relief of morphine and like drugs is a poignant one, but apparently no small

135. The management of intractable pain in cancer may be grouped under two main categories: (1) measures which check, decrease or eliminate the growth itself, (2) symptomatic treatment, *i.e.*, control of the pain without affecting the growth. In the first category are palliative operations for cancers no longer curable; radiation, roentgen and X-ray therapy; administration of endocrine substances, steroids, nitrogen mustards, and radioactive iodine and iron. See text, at notes 98-113 *supra*. In the second category are non-narcotic analgesics such as cobra venom, hypnotics and sedatives; narcotic analgesics, such as morphine, codeine, methadone and, recently, chlorpromazine; neurosurgical operations, such as rhizotomy, the technique of choice in the management of cancer pain of the head and neck, spinothalamic tractotomy and chordotomy, for relief of pain at or below the nipple line; and prefrontal lobotomy.

The various measures sketched above are discussed at considerable length in Bonica and Backup, *Control of Cancer Pain*, 54 Nw. Med. 22 (1955); Bonica, *The Management of Cancer Pain*, G. P., Nov. 1954, p. 35, and more extensively by Doctors Schiffrin and Gross (*Systematic Analgetics*), Sadove and Balogot (*Nerve Blocks For Pain In Malignancy*), Sugar (*Neurosurgical Aspects of Pain Management*), Taylor and Schiffrin (*Humoral and Chemical Palliation of Malignancy*) Schwarz (*Surgical Procedures In Control Of Pain In Advanced Cancer*) and Carpender (*Radiation Therapy In The Relief Of Pain In Malignant Disease*) in *The Management Of Pain In Cancer* (Schiffrin ed. 1956).

Relief of pain by nerve blocking "has a great deal more to offer than prolonged narcotic therapy. Effective blocks produce adequate relief of pain and enable these sufferers to receive more intensive radiation therapy and other forms of medical treatment which otherwise could not be tolerated." Bonica and Backup, *supra* at 27; Bonica, *supra*, at 43. "A recent analysis of cases reported in the literature revealed that of the many patients treated by alcohol nerve blocking, 63 per cent obtained complete relief, 23.5 per cent obtained partial relief, and only 13.5 per cent received no benefits from the blocks." Bonica, *supra*, at 43.

"Chordotomy is perhaps the most useful and most effective neurosurgical operation for the relief of cancer pain. When skillfully carried out in properly selected patients, it produces complete relief in about 65 per cent of the patients, partial relief in another 25 per cent, and no relief in approximately 10 per cent." Bonica and Backup, *supra* at 25.

Prefrontal lobotomy is a radical procedure which many regard as a last resort. Bilateral prefrontal lobotomy almost always produces striking changes in the patient's personality, frequently impairing judgment and causing apathy; the mental changes produced by unilateral lobotomy are much less marked, but pain is likely to recur if the patient survives more than several months. See Sugar, *supra*, at 101-104; Bonica, *supra* at 41-42.

136. Foreword by Dr. Warren H. Cole in *Management of Pain In Cancer* (Schiffrin ed. 1956).

137. Bonica and Backup, *supra* note 135, at 22; Bonica, *supra* note 135, at 35.

138. *Ibid.*

number of these situations may have been brought about by premature or excessive application of these drugs.¹³⁹ Psychotherapy "unfortunately . . . has barely been explored"¹⁴⁰ in this area, although a survey conducted on approximately 300 patients with advanced cancer disclosed that "over 50 per cent of patients who had received analgesics for long periods of time could be adequately controlled by placebo medication."¹⁴¹ Nor should it be overlooked that nowadays drugs are only one of many ways—and by no means always the most effective way—of attacking the pain problem. Radiation, roentgen and X-ray therapy; the administration of various endocrine

139. "The efficacy of *narcotics analgesics*, particularly opiates, in managing pain of terminal malignancy, is too well known to warrant discussion. . . . Unfortunately their effectiveness, low cost, and ease of administration—very desirable qualities in any drug—are conducive to improper use by the busy practitioner. He may have neither time nor the interest to study and consider each case individually so that the pharmacologic properties of the various narcotic drugs are fully exploited to the advantage of the patient. The attitude and practice of some physicians to "snow the patient under because the end is inevitable" denotes lack of understanding of the problem. Because it is very difficult to estimate the length of life in each individual case, such sense of mistaken humanitarianism may be productive of an unnecessarily premature addiction with consequent stupefaction, respiratory depression, headache, anorexia, nausea, vomiting, and will bring on a state of cachexia more rapidly. Moreover, because tolerance develops rapidly, the patient may not obtain adequate relief in the latter stages of the disease, when comfort is so essential, even with massive doses, and he may also develop withdrawal symptoms when the amount administered is no longer effective."

Bonica and Backup, *supra* note 135, at 24-25; to the same effect is Bonica, *supra* note 135, at 38.

See also Schiffrin and Gross, *supra* note 135, at 17:

"Factors facilitating the development of tolerance include the administration of the drug at frequent, regular intervals and the use of successively larger doses. The appearance of clinically significant tolerance can be delayed by using the minimal effective dose as infrequently as possible and by limiting the use of addicting drugs to their primary characteristic, analgesia, and not to secondary properties such as sedation. The writing of such an order as '¼ gr. morphine q. 4 h.' is to be deplored. Addicting analgetics are to be ordered on the basis of pain, not according to the clock or nursing habits."

140. "The opinion appears to prevail in the medical profession that severe pain requiring potent analgesics and narcotics frequently occurs in advanced cancer. Fortunately, this does not appear to be the case. Fear and anxiety, the patient's need for more attention from the family or from the physician, are frequently mistaken for expressions of pain. Reassurance and an unhesitating approach in presenting a plan of management to the patient are well known patient 'remedies,' and probably the clue to success of many medical quackeries. Since superficial psychotherapy as practiced by physicians without psychiatric training is often helpful, actual psychiatric treatment is expected to be of more value. Unfortunately, the potential therapeutic usefulness of this tool has barely been explored." Laszlo and Spencer, *Medical Problems In The Management Of Cancer*, 37 *Med. Clinics of N. A.* 869, 875 (1953).

141. *Ibid.* "Placebo" medication is medication having no pharmacologic effect given for the purpose of pleasing or humoring the patient. The survey was conducted on patients in Montefiore Hospital, N.Y.C. One clear implication is that "analgesics should be prescribed only after an adequate trial of placebos."

substances; intrathecal alcohol injections and other types of nerve blocking; and various neurosurgical operations such as spinothalamic chordotomy and spinothalamic tractomy, have all furnished striking relief in many cases.¹⁴² These various formidable non-narcotic measures, it should be added, are conspicuously absent from the prolific writings of the euthanasiasts.

That of those who do suffer and must necessarily suffer the requisite pain, many *really* desire death, I have considerable doubt.¹⁴³ Further, that of those who may desire death at a given moment, many have a fixed and rational desire for death, I likewise have considerable doubt.¹⁴⁴ Finally, taking those who may have such a desire, again I must register a strong note of skepticism that many cannot do the job themselves.¹⁴⁵ It is not that I condone suicide. It is simply that for reasons discussed in subsequent sections of this paper I find it easier to prefer a *laissez-faire* approach in such matters over an approach aided and sanctioned by the state.

The need is only one variable. The incidence of mistake is another. Can it not be said that although the need is not very great it is great enough to outweigh the few mistakes which are likely to

142. See note 135, *supra*.

143. The one thing agreed upon by the eminent physicians Abraham L. Wolbarst, later an officer of the Euthanasia Society of America, and James J. Walsh in their debate on "The Right To Die" was that very, very few people ever really want to die.

Dr. Walsh reported that in all the time he worked at Mother Alphonsa's Home for Incurable Cancer he never heard one patient express the wish that he "would be better off dead" and "I know, too, that Mother Alphonsa had very rarely heard it." "On the other hand," adds Walsh, "I have often heard neurotic patients wish that they might be taken out of existence because they could no longer bear up under the pain they were suffering. . . . They were overcome mainly by self-pity. Above all, they were sympathy seekers . . . of physical pain there was almost no trace, but they were hysterically ready, so they claimed to welcome death. . . . Walsh, *Life Is Sacred*, 94 *The Forum* 333 (1935). Walsh's opponent, Dr. Wolbarst, conceded at the outset that "very few incurables have or express the wish to die. However great their physical suffering may be, the will to live, the desire for life, is such an overwhelming force that pain and suffering become bearable and they prefer to live." Wolbarst, *Legalize Euthanasia!*, 94 *The Forum* 330 (1935).

The first "lesson" the noted British physician, A. Leslie Banks, learned as Resident Officer to cancer wards at the Middlesex Hospital was that "the patients, however ill they were and however much they suffered, never asked for death." Banks, *Euthanasia*, 26 *Bull. N.Y. Acad. Med.* 297, 301 (1950).

144. See text at notes 49 and 52 *supra*.

145. In *Euthanasia—Right or Wrong*, Survey Graphic, May, 1948, p. 241, Selwyn James makes considerable hay of the Euthanasia Society of America's claim that numerous cancer patients phone the society and beg for a doctor who will give them euthanasia. If a person retains sufficient physical and mental ability to look up a number, get to a phone and dial, does he really have to ask *others* to deal him death? That is, if it is death he really desires, and not, say, attention or pity.

occur? I think not. The incidence of error may be small in euthanasia, but as I have endeavored to show, and as Professor Williams has not taken pains to deny, under our present state of knowledge appreciable error is inevitable. *Some*, no matter how severe the pain, no matter how strikingly similar the symptoms, will not be cancer victims or other qualified candidates for euthanasia. Furthermore, among those who are in fact so inflicted, there are bound to be *some* who no matter how "hopeless" their plight at the moment, would be able to benefit from some treatment. That is, they would have been able to lead relatively normal, reasonably useful lives for, say, six months or a year, if death had not come until it came in its own way in its own time.

How many are "*some*"? I do not know, but I think they are a good deal more than *de minimus*. The business of predicting what cures or temporary checks or measures of relief from pain are around the corner is obviously an inexact science. And as for error in diagnosis, doctors, as a rule, do not contribute to *True Confessions*.¹⁴⁶ But I venture to say that the percentage and the absolute figures would not be as small, certainly not any smaller, than the grants of federal habeas corpus petitions to set aside state convictions. Federal habeas corpus so operates that only a handful of petitions are granted and only a small fraction of these cases are ultimately discharged.¹⁴⁷ Yet its continued existence has been ably

146. See, e.g., *Proceedings, Symposium on Exfoliative Cytology* at 58 (Oct. 23-24, 1951):

Dr. Mortimer Benioff: Dr. [Peter] Herbert is to be congratulated on showing you particularly some of the cases which were operated on and did not have cancer. Most of the time we have a tendency in our enthusiasm not to talk about things like that. . . .

147. During the nine years from 1946 through 1954, only 79 or 1.6% of 4,849 federal habeas corpus applications were granted. In 1954, the percentage was down to 1.3; in 1955 it had fallen below 1 per cent: 5 out of 688 cases. See Baker, *Federal Judicial Control of State Criminal Justice*, 22 Mo. L. Rev. 109, 140 (1957); Pollak, *Proposals to Curtail Federal Habeas Corpus for State Prisoners: Collateral Attack on the Great Writ*, 66 Yale L. J. 50, 53 (1956); Ribble, *A Look at the Policy Making Powers of the United States Supreme Court and the Position of the Individual*, 14 Wash. & Lee L. Rev. 167, 178-9 (1957); Schaefer, *Federalism and State Criminal Procedure*, 70 Harv. L. Rev. 1, 19 (1956). Of course, these figures do not necessarily reflect the actual proportion of meritorious cases. Professor Pollak suggests that the very low measure of success is due in no small degree to the difficulties of proof involved in reconstructing trials of the distant past and the ineptness of prisoners handling their own past-conviction litigation, 66 Yale L. J. at 54, while Professor Baker takes the contrary position that "if even the federal courts themselves must admit that the state tribunals have been correct at least 98.6 [98.4?] per cent of the time when their convictions have been challenged, it is not completely amiss to surmise that the state courts may have been right in those few cases where the writs were granted and the prisoners discharged," 22 Mo. L. Rev. at 140. I, for one, find Pollak's reasoning more persuasive, but I think it fair to say that

defended as but another example of the recurrent theme that it is better that many guilty go free than one innocent be convicted.¹⁴⁸ So long as this is the vogue, I do not hesitate—although Williams evidently thinks it is "no contest"—to pit the two or three or four who might be saved against the hundred who cannot be.

Even if the need for voluntary euthanasia could be said to outweigh the risk of mistake, this is not the end of the matter. That "all that can be expected of any moral agent is that he should do his best on the facts as they appear to him"¹⁴⁹ may be true as far as it goes, but it would seem that where the consequence of error is so irreparable it is not too much to expect of society that there be *a good deal more than one moral agent* "to do his best on the facts as they appear to him." It is not too much to expect for example, that something approaching the protection thrown around one who appears to have perpetrated a serious crime be extended to one who appears to have an incurable disease. Williams' proposal falls far short of this mark.

most defenders of the writ are willing to take the figures as they find them.

Yet, of the handful whose petitions were granted, how many actually get relief? In 1953, Mr. Justice Frankfurter noted that "during the last four years five state prisoners, all told, were discharged by federal district courts," *Brown v. Allen*, 344 U.S. 443, 510 (1953) (dissenting opinion), "the minuscule figure of .15 per cent", as one of the writ's staunchest friends has put it. Pollak, *supra*, at 53.

148. It is not surprising that the cry has gone out that federal habeas corpus is not worth it, that "one swallow does not make a summer", Baker, *supra* note 147 at 1042, and that "he who must search a haystack for a needle is likely to end up with the attitude that the needle is not worth the search." Jackson, J., concurring in *Brown v. Allen*, 344 U.S. 443, 537 (1953). But these views have not prevailed. As Illinois Supreme Court Justice Walter Schaefer recently observed in his Holmes lecture:

Even with the narrowest focus it is not a needle we are looking for in these stacks of paper, but the rights of a human being. And if the perspective is broadened, even the significance of that single human being diminishes, and we begin to catch a glimpse of the full picture. The aim which justifies the existence of habeas corpus is not fundamentally different from that which informs our criminal law in general, that it is better that a guilty man go free than that an innocent one be punished. To the extent that the small numbers of meritorious petitions shows that the small numbers of meritorious petitions shows that the standards of due process are being honored in criminal trials we should be gratified; but the continuing availability of the federal remedy is in large part responsible for that result. What is involved, however, is not just the enforcement of defined standards. It is also the creative process of writing specific content into the highest of our ideals. So viewed, the burdensome test of shifting the meritorious from the worthless appears less futile. . . .

Schaefer, *supra* note 147 at 25-26.

I think Justice Schaefer would agree that his thought is more often articulated in terms of "it is better to let a *hundred* guilty men go free than to convict one innocent." See Kadish, *Methodology and Criteria in Due Process Adjudication—A Survey and Criticism*, 66 Yale L.J. 319, 346 (1957).

149. Williams, p. 318.

II. A LONG-RANGE VIEW OF EUTHANASIA

A. *Voluntary v. Involuntary Euthanasia.*

Ever since the 1870's, when what was probably the first euthanasia debate of the modern era took place,¹⁵⁰ most proponents of the movement—at least when they are pressed—have taken considerable pains to restrict the question to the plight of the unbearably suffering incurable who *voluntarily seeks* death while most of their opponents have striven equally hard to frame the issue in terms which would encompass certain involuntary situations as well, *e.g.*, the “congenital idiots,” the “permanently insane,” and the senile.

Glanville Williams reflects the outward mood of many euthanasiasts when he scores those who insist on considering the question from a broader angle:

The [English Society's] bill [debated in the House of Lords in 1936 and 1950] excluded any question of compulsory euthanasia, even for hopelessly defective infants. Unfortunately, a legislative proposal is not assured of success merely because it is worded in a studiously moderate and restrictive form. The method of attack, by those who dislike the proposal, is to use the ‘thin edge of the wedge’ argument. . . . There is no pro-

150. L. A. Tollemache—and not since has there been a more persuasive euthanasiast—made an eloquent plea for voluntary euthanasia, *The New Cure for Incurables*, 19 *Fortnightly Review* 218 (1873), in support of a similar proposal the previous year, S. D. Williams, *Euthanasia* (1872), (a book now out of print, but a copy of which is at the British Museum). Tollemache's article was bitterly criticized by the editors of *The Spectator*, *Mr. Tollemache on The Right To Die*, 46 *The Spectator* 206 (1873) who stated in part:

[I]t appears to be quite evident, though we do not think it is expressly stated in Mr. Tollemache's article, that much the strongest arguments to be alleged for putting an end to human sufferings apply to cases where you cannot by any possibility have the consent of the sufferer to that course.

In a letter to the editor, *The Limits of Euthanasia*, 46 *The Spectator* 240 (1873), Mr. Tollemache retorted:

I tried to make it clear that I disapproved of such relief ever being given without the dying man's express consent. . . . But it is said that all my reasoning would apply to cases like lingering paralysis, where the sufferer might be speechless. I think not . . . where these safeguards cannot be obtained, the sufferer must be allowed to linger on. Half a loaf, says the proverb, is better than no bread; one may be anxious to relieve what suffering one can, even though the conditions necessary for the relief of other (and perhaps worse) suffering may not exist. . . . I have stated my meaning thus fully, because I believe it is a common misunderstanding of Euthanasia, that it must needs involve some such proceedings as the late Mr. Charles Buxton advocated (not perhaps quite seriously),—namely, the summary extinction of idiots and of persons in their dotage.

I give this round to the voluntary euthanasiasts.

posal for reform on any topic, however conciliatory and moderate, that cannot be opposed by this dialectic.¹⁵¹

Why was the bill "worded in a studiously moderate and restrictive form?" If it were done as a matter of principle, if it were done in recognition of the ethico-moral-legal "wall of separation" which stands between voluntary and compulsory "mercy-killings," much can be said for the euthanasiasts' lament about the methods employed by the opposition. But if it were done as a matter of political expediency—with great hopes and expectations of pushing through a second and somewhat less restrictive bill as soon as the first one had sufficiently "educated" public opinion and next a third still less restrictive bill—what standing do the euthanasiasts then have to attack the methods of the opposition? No cry of righteous indignation could ring more hollow, I would think, than the protest from those utilizing the "wedge" principle themselves that their opponents are making the wedge objection.

In this regard the words and action of the euthanasiasts are not insignificant.

No sooner had the English Society been organized and a drive to attain "easy death" legislation launched than Dr. Harry Roberts, one of the most distinguished sympathizers of the movement, disclosed some basis for alarm as to how far the momentum would carry:

So far as its defined objects go, most informed people outside the Catholic Church will be in general sympathy with the new Society; but lovers of personal liberty may feel some of that suspicion which proved so well justified when the Eugenics movement was at its most enthusiastic height.

In the course of the discussion at the [1935] Royal Sanitary Institute Congress, two distinguished doctors urged the desirability of legalizing the painless destruction of 'human mental monstrosities' in whom improvement is unattainable; and at the inaugural meeting of the Euthanasia Legislation Society, the Chairman of the Executive Committee said that 'they were concerned to-day only with voluntary euthanasia; but, as public opinion developed, and it became possible to form a truer estimate of the value of human life, further progress along preventive lines would be possible. . . . The population was an ageing one, with a larger relative proportion of elderly persons—individuals who had reached a degenerative stage of life. Thus the total amount of suffering and the number of useless lives must increase.'

We need to discriminate very carefully between facilitating the death of an individual at his own request and for his own relief,

151. Williams, pp. 333-34.

and the killing of an individual on the ground that, for the rest of us such a course would be more economical or more agreeable than keeping him alive.¹⁵²

In the 1936 debate in the House of Lords, Lord Ponsonby of Shulbrede, who moved the second reading of the voluntary euthanasia bill, described two appealing actual cases, one where a man drowned his four-year-old daughter "who had contracted tuberculosis and had developed gangrene in the face,"¹⁵³ another where a woman killed her mother who was suffering from "general paralysis of the insane."¹⁵⁴ Both cases of course were of the compulsory variety of euthanasia. True, Lord Ponsonby readily admitted that these cases were not covered by the proposed bill, but the fact remains that they were the *only* specific cases he chose to describe.

In 1950, Lord Chorley once again called the voluntary euthanasia bill to the attention of the House of Lords. He was most articulate, if not too discreet, on excluding compulsory euthanasia cases from coverage:

Another objection is that the Bill does not go far enough, because it applies only to adults and does not apply to children who come into the world deaf, dumb and crippled, and who have a much better cause than those for whom the Bill provides. That may be so, but we must go step by step.¹⁵⁵

In 1938, two years after the English Society was organized and its bill had been introduced into the House of Lords, the Euthanasia Society of America was formed.¹⁵⁶ At its first annual meeting the following year, it offered proposed euthanasia legislation:

Infant imbeciles, hopelessly insane persons . . . and any person not requesting his own death would not come within the scope of the proposed act.

Charles E. Nixdorff, New York lawyer and treasurer of the society, who offered the bill for consideration, explained to some of the members who desired to broaden the scope of the proposed law, that it was *limited purposely to voluntary euthanasia because public opinion is not ready to accept the broader principle*. He said, however, that *the society hoped eventually to legalize the putting to death of nonvolunteers* beyond the help of medical science.¹⁵⁷

152. Roberts, Euthanasia and other Aspects of Life and Death 7-8 (1936).

153. 103 H.L. Deb. 466, 471 (1936).

154. *Ibid.*

155. 169 H.L. Deb. 551, 559 (1950).

156. N.Y. Times, Jan. 17, 1938, p. 21, col. 8.

157. N.Y. Times, Jan. 27, 1939, p. 21, col. 7 (emphasis added). That the report is accurate in this regard is underscored by Mr. Nixdorff's letter to the editor, N.Y. Times, Jan. 30, 1939, p. 12, col. 7, wherein he complained only that "the patient who petitions the court for euthanasia should not be

About this time, apparently, the Society began to circulate literature in explanation and support of voluntary euthanasia, as follows:

The American and English Euthanasia Societies, after careful consideration, have both decided that more will be accomplished by devoting their efforts at present to the measure which will probably encounter the least opposition, namely *voluntary euthanasia*. The public is readier to recognize the right to *die* than the right to *kill*, even though the latter be in mercy. To take someone's life without his consent is a very different thing from granting him release from unnecessary suffering at his own express desire. The freedom of the individual is highly prized in democracies.¹⁵⁸

The American Society's own "Outline of the Euthanasia Movement in the United States and England" states in part:

1941. A questionnaire was sent to all physicians of New York State asking (1) Are you in favor of legalizing voluntary euthanasia for incurable adult sufferers? (2) Are you in favor of legalizing euthanasia for congenital monstrosities, idiots and imbeciles? Because only $\frac{1}{3}$ as many physicians answered 'yes' to question 2 as to question 1, we decided that we would limit our program to voluntary euthanasia.¹⁵⁹

At a meeting of the Society of Medical Jurisprudence held several weeks after the American Society voluntary euthanasia bill had been drafted, Dr. Foster Kennedy, newly elected president of the Society, "urged the legalizing of euthanasia primarily in cases of born defectives who are doomed to remain defective, rather than for normal persons who have become miserable through incurable illness" and scored the "absurd and misplaced sentimental kindness" that seeks to preserve the life of a "person who is not a person." "If the law sought to restrict euthanasia to those who could speak out for it, and thus overlooked these creatures who cannot speak, then, I say as Dickens did, 'The law's an ass'".¹⁶⁰ As pointed out elsewhere, *while president* of the Society, Dr. Kennedy not only eloquently advocated involuntary euthanasia but strenuously *opposed* the voluntary variety.¹⁶¹ Is it any wonder that opponents of

described as a 'volunteer' and that "the best definition of euthanasia is 'merciful release' rather than 'mercy killing' or even mercy 'death'" because "being killed is associated with fear, injury and the desire to escape" and "many people dislike even to talk about death."

158. Dr. Frank Hinman of the University of California Medical School quotes such literature in *Euthanasia*, 99 J. Nerv. & Mental Diseases 640, 643 (1944).

159. Distributed by the Euthanasia Society of America.

160. N.Y. Times, Feb. 14, 1939, p. 2, col. 6.

161. See note 72 *supra* and accompanying text.

the movement do not always respect the voluntary-involuntary dichotomy?

At the same time that Dr. Kennedy was disseminating his "personal" views, Dr. A. L. Wolbarst, long a stalwart in the movement, was adhering much more closely to the party line. In a persuasive address to medical students published in a leading medical journal he pointed out that "a bill is now in preparation for introduction in the New York State Legislature authorizing the administration of euthanasia to incurable sufferers on their own request"¹⁶² and stressed that "the advocates of voluntary euthanasia do not seek to impose it on any one who does not ask for it. It is intended as an act of mercy for those who need it and demand it."¹⁶³ What were Dr. Wolbarst's views before the English and American societies had been organized and substantial agreement reached as to the party platform? Four years earlier, in a debate on euthanasia, he stated:

The question as usually submitted limits the discussion of legal euthanasia to those 'incurables whose physical suffering is unbearable to themselves.' That limitation is rather unfortunate, because the number of incurables within this category is actually and relatively extremely small. Very few incurables have or express the wish to die. However great their physical suffering may be . . . they prefer to live.

If legal euthanasia has a humane and merciful motivation, it seems to me the entire question should be considered from a broad angle. There are times when euthanasia is strongly indicated as an act of mercy even though the subject's suffering is not 'unbearable to himself,' as in the case of an imbecile.

It goes without saying that, in recently developed cases with a possibility of cure, euthanasia should not even be considered; but when insane or defective people have suffered mental incapacity and tortures of the mind for many years—forty-three years in a case of my personal knowledge—euthanasia certainly has a proper field.¹⁶⁴

In his 1939 address, Dr. Wolbarst also quoted in full the stirring suicide message of Charlotte Perkins Gilman, "described as one of the twelve greatest American women [who] had been in failing health for several years and chose self-euthanasia rather than endure the pains of cancer."¹⁶⁵ He would have presented Mrs. Gilman's views more fully if he had quoted as well from her last article, left

162. Wolbarst, *The Doctor Looks at Euthanasia*, 149 *Medical Record* 354, 355 (1939).

163. *Id.* at 354.

164. Wolbarst, *Legalize Euthanasia!*, 94 *The Forum* 330-32 (1935).

165. Wolbarst, *supra* note 162 at 356.

with her agent to be published after her death, where she advocates euthanasia for "incurable invalids", "hopeless idiots", "helpless paretics", and "certain grades of criminals".¹⁶⁶ Citing with approval the experience of "practical Germany", Miss Gilman's article asserted that "the dragging weight of the grossly unfit and dangerous could be lightened" by legalized euthanasia, "with great advantage to the normal and progressive. The millions spent in restraining and maintaining social detritus should be available for the safeguarding and improving of better lives."¹⁶⁷

In 1950, the "mercy killings" perpetrated by Dr. Herman N. Sander on his cancer-stricken patient and by Miss Carol Ann Paight on her cancer-stricken father put the euthanasia question on page one.¹⁶⁸ In the midst of the fervor over these cases, Dr. Clarence Cook Little, one of the leaders in the movement and a former president of the American Society, suggested specific safeguards for a law legalizing "mercy killings" for the "incurably ill but mentally fit" and for "mental defectives."¹⁶⁹ The Reverend Charles Francis Potter, the founder and first president of the American Society hailed Dr. Sander's action as "morally right" and hence that which "should be legally right."¹⁷⁰ Shortly thereafter, at its annual meeting, the American Society "voted to continue support" of both Dr. Sander and Miss Paight.¹⁷¹

Now, one of the interesting, albeit underplayed, features of these cases—and this was evident all along—was that both were *involuntary* "mercy killings". There was considerable conflict in the testimony at the Sander Trial as to whether or not the victim's husband had pleaded with the doctor to end her suffering,¹⁷² but

166. Gilman, *The Right to Die*, 94 *The Forum* 297-300 (1935).

167. *Ibid.*

168. See notes 172-176 *infra*. More than 100 reporters, photographers and broadcasters attended the Sander trial. In ten days of court sessions, the press corps filed 1,600,000 words. *Not Since Scopes?* *Time*, March 13, 1950, p. 43.

169. *N.Y. Times*, Jan. 12, 1950, p. 54, col. 1.

170. *N.Y. Times*, Jan. 9, 1950, p. 40, col. 2.

171. *N.Y. Times*, Jan. 18, 1950, p. 33, col. 5.

172. *N.Y. Times*, Feb. 24, 1950, p. 1, col. 6; Feb. 28, 1950, p. 1, col. 2, "Similar to Murder," *Time*, March 6, 1950, p. 20. Although Dr. Sander's own notation was to the effect that he had given the patient "ten cc of air intravenously repeated four times" and that the patient "expired within ten minutes after this was started," *N.Y. Times*, Feb. 24, 1950, p. 15, col. 5; "Similar To Murder," *Time*, March 6, 1950, p. 20, and the attending nurse testified that the patient was still "gasping" when the doctor injected the air, *N.Y. Times*, Feb. 28, 1950, p. 1, col. 2, the defendant's position at the trial was that the patient was dead before he injected the air, *N.Y. Times*, March 7, 1950, p. 1, col. 1; *The Obsessed*, *Time*, March 13, 1950, p. 23; his notes were not meant to be taken literally, "it's a casual dictation . . . merely a way of closing out the chart," *N.Y. Times*, March 7, 1950, p. 19, col. 2. Dr. Sander was acquitted, *N.Y. Times*, March 10, 1950, p. 1, col. 6. The alleged mercy-killing

nobody claimed that the victim herself had done such pleading. There was considerable evidence in the *Paight* case to the effect that the victim's daughter had a "cancer phobia," the cancer deaths of two aunts having left a deep mark on her,¹⁷³ but nobody suggested that the victim had a "cancer phobia."

It is true that Mother Paight said approvingly of her mercy-killing daughter that "she had the old Paight guts,"¹⁷⁴ but it is no less true that Father Paight had no opportunity to pass judgment on the question. He was asleep, still under the anesthetic of the exploratory operation which revealed the cancer in his stomach when his daughter, after having taken one practice shot in the woods, fired into his left temple.¹⁷⁵ Is it not just possible that Father Paight would have preferred to have had the vaunted Paight intestinal fortitude channelled in other directions, e.g., by his daughter bearing to see him suffer?¹⁷⁶

The *Sander* and *Paight* cases amply demonstrate that to the press, the public, and many euthanasiasts, the killing of one who does not or cannot speak is no less a "mercy killing" than the killing of one who asks for death. Indeed, the overwhelming majority of known or alleged "mercy killings" have occurred without the consent of the victim. If the *Sander* and *Paight* cases are atypical at all, they are so only in that the victims were not ill or retarded children, as in the *Simpson*,¹⁷⁷ *Brownhill*¹⁷⁸ and *Long*¹⁷⁹ English

split the patient's family. The husband and one brother sided with the doctor; another brother felt that the patient's fate "should have been left to the will of God." 40 *cc of Air*, Time, Jan. 9, 1950, p. 13. Shortly afterwards, Dr. Sander's license to practice medicine in New Hampshire was revoked, but was soon restored. N.Y. Times, June 29, 1950, p. 31, col. 6. He was also ousted from his county medical society, but after four years of struggle gained admission to one. N.Y. Times, Dec. 2, 1954, p. 25, col. 6.

173. N.Y. Times, Jan. 28, 1950, p. 30, col. 1, Feb. 1, 1950, p. 54, col. 3, Feb. 2, 1950, p. 22, col. 5; *For Love or Pity*, Time, Feb. 6, 1950, p. 15; *The Father Killer*, Newsweek, Feb. 13, 1950, p. 21. Miss Paight was acquitted on the ground of "temporary insanity" N.Y. Times, Feb. 8, 1950, p. 1, col. 2.

174. *The Father Killer*, Newsweek, Feb. 13, 1950, p. 21.

175. See note 173, *supra*. Miss Paight was obsessed with the idea that "daddy must never know he had cancer," N.Y. Times, Jan. 28, 1950, p. 30, col. 1.

176. "I had to do it. I couldn't bear to see him suffering." . . . Once, when she woke up from a strong sedative, she said: 'Is daddy dead yet? I can't ever sleep until he is dead.'" *The Father Killer*, Newsweek, Feb. 13, 1950, p. 21.

177. *Rex v. Simpson*, 11 Crim. App. R. 218, 84 L.J.K.B. 1893 (1915) dealt with a young soldier on leave, who, while watching his severely ill child and waiting for his unfaithful wife to return home, cut the child's throat with a razor. His statement was as follows:

The reason why I done it was I could not see it suffer any more than what it really had done. She was not looking after the child, and it was lying there from morning to night, and no one to look after it, and I could not see it suffer any longer and have to go away and leave it.

Simpson was convicted of murder and his application for leave to appeal

cases, and the *Greenfield*,¹⁸⁰ *Repouille*,¹⁸¹ *Noxon*¹⁸² and *Braunsdorf*¹⁸³ American cases.

dismissed. The trial judge was held to have properly directed the jury that they were not at liberty to find a verdict of manslaughter, though the prisoner killed the child "with the best and kindest motive."

178. Told to undergo a serious operation, and worried about the fate of her 31-year-old imbecile son if she were to succumb, 62-year-old Mrs. May Brownhill took his life by giving him about 100 aspirins and then placing a gas tube in his mouth. *The Times* (London), Oct. 2, 1934, p. 11, col. 2; *N.Y. Times*, Dec. 2, 1934, p. 25, col. 1, Dec. 4, 1934, p. 15, col. 3. Her family doctor testified that the boy's life had been "a veritable living death" *The Times* (London), Dec. 3, 1934, p. 11, col. 4. She was sentenced to death, with a strong recommendation for mercy, *The Times* (London), Dec. 3, 1934, p. 11, col. 4; *N.Y. Times*, Dec. 2, 1934, p. 25, col. 1, but she was reprieved two days later, *The Times* (London), Dec. 4, 1934, p. 14, col. 2; and pardoned and set free three months later, *The Times* (London), March 4, 1935, p. 11, col. 3; *Mother May's Holiday*, *Time*, March 11, 1935, p. 21. According to the *N.Y. Times*, March 3, 1935, p. 3, col. 2, the Home Office acted "in response to nation-wide sentiment." The Chicago Tribune report of the case is reprinted in Harno, *Criminal Law and Procedure* 36 n. 2 (4th ed. 1957).

Incidentally, Mrs. Brownhill's operation was quite successful. *The Times* (London), Dec. 3, 1934, p. 11, col. 4.

179. Gordon Long gassed his deformed and imbecile 7-year-old daughter to death, stating he loved her "more so than if she had been normal." "Goodbye," *Time*, Dec. 2, 1946, p. 32. He pleaded guilty and was sentenced to death, but within a week the sentence was commuted to life imprisonment. *The Times* (London), Nov. 23, 1946, p. 2, col. 7, Nov. 29, 1946, p. 2, col. 7; *N.Y. Times*, Nov. 29, 1946, p. 7, col. 2.

180. For 17 years, Louis Greenfield, a prosperous Bronx milliner, had washed, dressed and fed his son, an "incurable imbecile" with the mentality of a two-year-old who spoke in a mumble understandable only by his mother. *N.Y. Times*, Jan. 13, 1939, p. 3, col. 1, May 12, 1939, p. 1, col. 6. Finally, after considering killing him for several years, Greenfield sent his wife out of the house, lest she interfere with his plans, and chloroformed his son to death. He is reported to have told members of the emergency squad: "Don't revive him, he's better off dead," *N.Y. Times*, May 9, 1939, p. 48, col. 1. See also "Better Off Dead," *Time*, Jan. 23, 1939, p. 24.

At the trial Greenfield testified that he killed his son because "I loved him, it was the will of God." He insisted that he was directed by an "unseen hand" and by an "unknown voice" *N.Y. Times*, May 11, 1939, p. 10, col. 2 and was acquitted of first degree manslaughter, *N.Y. Times*, May 12, 1939, p. 1, col. 6. Some psychiatrists were reported to have condemned Greenfield as "a murderer who had simply grown tired of caring for his imbecile son." "Better Off Dead," *supra*.

181. This case is quite similar to the *Greenfield* case which preceded it by several months. In fact, Louis Repouille said he had read the newspaper accounts of the *Greenfield* case and:

It made me think about doing the same thing to my boy. I think Mr. Greenfield was justified. They didn't punish him for it. But I am not looking for sympathy. *N.Y. Times*, Oct. 14, 1939, p. 21, col. 2.

Repouille was an elevator operator who had spent his life's earnings trying to cure his "incurably imbecile" thirteen-year-old son who had been blind for five years and bedridden since infancy. Repouille is reported to have put it this way: "He was just like dead all the time. . . . He couldn't walk, he couldn't talk, he couldn't do anything." *N.Y. Times*, Oct. 13, 1939, p. 25, col. 7. He testified at the trial that the idea of putting his son out of his misery "came to me thousands of times," *N.Y. Times*, Dec. 6, 1941, p. 34, col. 2. Finally, one day when his wife stepped out of the house for a while, he chloroformed his son to death. *N.Y. Times*, Oct. 13, 1939, p. 25, col. 7.

Repouille kept a number of canaries and lovebirds in his home. When a neighbor found the Repouille boy with a chloroform-soaked rag over his face, he removed the rag and was about to throw it on the floor when

Repouille is reported to have said: "Don't, can't you see I have some birds here." *Ibid.*

Repouille was found guilty of manslaughter in the second degree, N.Y. Times, Dec. 10, 1941, p. 27, col. 7, and freed on a suspended sentence of 5-10 years. N.Y. Times, Dec. 25, 1941, p. 44, col. 1.

Subsequently, Repouille's petition for naturalization was dismissed on the ground that he had not possessed "good moral character" within the five years preceding the filing of the petition. In an opinion which makes *Repouille* the "mercy killing" perhaps best known to lawyers today, Judge Learned Hand said in part:

It is reasonably clear that the jury which tried Repouille did not feel any moral repulsion at his crime. Although it was inescapably murder in the first degree, not only did they bring in a verdict that was flatly in the face of the facts and utterly absurd—for manslaughter in the second degree presupposes that the killing has not been deliberate—but they coupled even that with a recommendation which showed that in substance they wished to exculpate the offender. Moreover, it is also plain, from the sentence which he imposed, that the judge could not have seriously disagreed with their recommendation.

* * *

Left at large as we are, without means of verifying our conclusion, and without authority to substitute our individual beliefs, the outcome must needs be tentative; and not much is gained by discussion. We can say no more than that, . . . we feel reasonably secure in holding that only a minority of virtuous persons would deem the practise morally justifiable, while it remains in private hands, even when the provocation is as overwhelming as it was in this instance.

Repouille v. United States, 165 F.2d 152, 153 (2d Cir. 1947).

182. John F. Noxon, a 46-year-old well-to-do lawyer, was charged with electrocuting his 6-month-old mongoloid son by wrapping a frayed electric light cord about him and placing him—in wet diapers—on a silver serving tray to form a contact. Noxon claimed it was all an accident. N.Y. Times, Sept. 28, 1943, p. 27, col. 2; Sept. 29, 1943, p. 23, col. 7; Oct. 29, 1943, p. 21, col. 7; Jan. 14, 1944, p. 21, col. 3; July 7, 1944, p. 30, col. 2; July 8, 1944, p. 24, col. 1. After a mistrial because a juror became ill, N.Y. Times, March 10, 1944, Noxon was convicted of first degree murder, N.Y. Times, July 7, 1944, p. 30, col. 2. His death sentence was commuted to life, but in granting the clemency, Gov. M. J. Tobin of Massachusetts did not explain the "extenuating circumstances" other than to caution that a "mercy-killing, so-called," could not be considered an extenuating circumstance and was not a factor in his decision. N.Y. Times, Aug. 8, 1946, p. 42, col. 4. To make parole possible, Noxon's sentence was further commuted to 6 years to life with the proviso that he would live under parole supervision for life upon release from prison. N.Y. Times, Dec. 30, 1948, p. 13, col. 5. Shortly thereafter, Noxon was paroled, N.Y. Times, Jan. 4, 1949, p. 16, col. 3; Jan. 8, 1949, p. 30, col. 4. He was disbarred the following year. N.Y. Times, May 30, 1950, p. 2, col. 7.

183. Virginia Braunsdorf was a spastic-crippled 29-year-old "helpless parody of womanhood," who could not hold her head upright and who talked in gobbling sounds which only her father could understand. At one time, to keep her home and well attended, her father, Eugene, a symphony musician, had held down four jobs simultaneously, but he finally resigned himself to leaving her at a private sanitarium. Worried about his health and the fate of his daughter if he should die, Braunsdorf took her from the sanitarium on a pretense, stopped his car, put a pillow behind her head, and shot her dead. He then attempted suicide. He was found not guilty by reason of temporary insanity. *Murder or Mercy?*, Time, June 5, 1950, p. 20; N.Y. Times, May 23, 1950, p. 25, col. 4.

The prosecution argued that the girl was "human" and "had a right to live" and accused Braunsdorf of slaying her because she was a "burden on his pocketbook." N.Y. Times, May 23, 1950, p. 25, col. 4. The prosecution failed to explain, however, why a person furthering his own financial interests by killing his daughter would then fire two shots into his own chest, and, on reviving, shoot himself twice more.

These situations are all quite moving. So much so that two of the strongest presentations of the need for *voluntary* euthanasia, free copies of which may be obtained from the American Society, lead off with sympathetic discussions of the *Brownhill* and *Greenfield* cases.¹⁸⁴ This, it need hardly be said, is not the way to honor the voluntary-involuntary boundary. Not the way to ease the pressure to legalize at least this type of involuntary euthanasia as well if any changes in the broad area are to be made at all.

Nor, it should be noted, is Williams free from criticism in this regard. In his discussion of "the present law," apparently a discussion of voluntary euthanasia, he cites only one case, *Simpson*, an involuntary situation.¹⁸⁵ In his section on "the administration of the law" he describes only the *Sander* case and the "compassionate acquittal" of a man who drowned his four-year-old daughter, a sufferer of tuberculosis and gangrene of the face.¹⁸⁶ Again, both are involuntary cases. For "some other" American mercy-killing cases, Williams refers generally to an article by Helen Silving,¹⁸⁷ but two of the three cases he seems to have in mind are likewise cases of involuntary euthanasia.¹⁸⁸

That the press and general public are not alone in viewing an act as a "mercy killing," lack of consent on the part of the victim notwithstanding, is well evidenced by the recent deliberations of the

184. In *The Doctor Looks At Euthanasia*, 149 Medical Record 354 (1939), Dr. Wolbarst describes the *Brownhill* case as an "act of mercy, based on pure mother-love" for which, thanks to the growth of the euthanasia movement in England, "it is doubtful that this poor woman even would be put on trial at the present day."

In *Taking Life Legally*,—Magazine Digest—(1947), Louis Greenfield's testimony that what he did "was against the law of man, but not against the law of God" is cited with apparent approval. The article continues:

The acquittal of Mr. Greenfield is indicative of a growing attitude towards euthanasia, or 'mercy killing', as the popular press phrases it. Years ago, a similar act would have drawn the death sentence; today, the mercy killer can usually count on the sympathy and understanding of the court—and his freedom.

185. Williams, p. 319 and n. 9. For a discussion of the *Simpson* case, see note 177 *supra*.

186. Williams, p. 328. For a discussion of the *Sander* case, see note 172 *supra*. The other case as Williams notes, p. 328 n. 5, is the same one described by Lord Ponsonby in the 1936 House of Lords debate. See text at note 153 *supra*.

187. Williams, p. 328. Williams does not cite to any particular page of the thirty-nine page Silving article, *Euthanasia: A Study In Comparative Criminal Law*, 103 U. of Pa. L. Rev. 350 (1954), but in context he appears to allude to pp. 353-54 of the article.

188. In addition to the *Sander* case, the cases Williams makes apparent reference to are the *Paight* case, see notes 173-76 *supra* and accompanying text; the *Braunsdorf* case, see note 183 *supra*; and the *Mohr* case, see note 17 *supra*. Only in the *Mohr* case was there apparently euthanasia by request.

Royal Commission on Capital Punishment.¹⁸⁹ The Report itself described "mercy killings" as "for example, where a mother has killed her child or a husband has killed his wife from merciful motives of pity and humanity."¹⁹⁰ The only specific proposal to exclude "mercy killings" from the category of murder discussed in the Report is a suggestion by the Society of Labour Lawyers which disregards the voluntary-involuntary distinction:

If a person who has killed another person proves that he killed that person with the compassionate intention of saving him physical or mental suffering he shall not be guilty of murder.¹⁹¹

Another proposal, one by Hector Hughes, M. P., to the effect that only those who "maliciously" cause the death of another shall be guilty of murder,¹⁹² likewise treated the voluntary and involuntary "mercy killer" as one and the same.

Testimony before the Commission underscored the great appeal of the *involuntary* "mercy killings." Thus, Lord Goddard, the Lord Chief Justice, referred to the famous *Brownhill* case, which he himself had tried some fifteen years earlier, as "a dreadfully pathetic case."¹⁹³ "The son," he pointed out, "was a hopeless imbecile, more than imbecile, a mindless idiot."¹⁹⁴

Mr. Justice Humphreys recalled "one case that was the most pathetic sight I ever saw,"¹⁹⁵ a case which literally had the trial judge, Mr. Justice Hawkins, in tears. It involved a young father

189. According to the Royal Warrant, the Commission was appointed in May, 1949, "to consider and report whether liability under the criminal law in Great Britain to suffer capital punishment for murder should be limited or modified," but was precluded from considering whether capital punishment should be abolished. Royal Commission on Capital Punishment, Report, Cmd. No. 8932, at p. iii (1953) (called henceforth the Royal Commission Report). For an account of the circumstances which led to the appointment of the Commission, see Prevezer, *The English Homicide Act: A New Attempt to Revise the Law of Murder*, 57 Colum. L. Rev. 624, 629 (1957).

190. "It was agreed by almost all witnesses" that it would "often prove extremely difficult to distinguish killings where the motive was merciful from those where it was not". Royal Commission Report, at Para. 179 (1953). Thus the Commission "reluctantly" concluded that "it would not be possible" to frame and apply a definition which would satisfactorily cover these cases. *Id.*, at para. 180.

191. Royal Commission Report at para. 180 (1953).

192. Minutes of Evidence, pp. 219-20 (Dec. 1, 1949) Mr. Hughes, however, would try the apparent "mercy killer" for murder rather than for manslaughter "because the evidence should be considered not *in camera* but in open court, when it may turn out that it was not manslaughter." *Id.*, at para. 2825. "[T]he onus should rest upon the person so charged to prove that it was not a malicious, but a merciful killing." *Id.*, at para. 2826.

193. Minutes of Evidence, para. 3120 (Jan. 5, 1950). The Lord Chief Justice did not refer to the case by name, but his reference to *Brownhill* is unmistakable. For an account of this case, see note 178 *supra*.

194. Minutes of Evidence, para. 3120 (Jan. 5, 1950).

195. *Id.* at para. 3315.

who smothered his infant child to death when he learned the child had contracted syphilis from the mother (whose morals turned out to be something less than represented) and would be blind for life. "That," Mr. Justice Humphreys told the Commission, "was a real 'mercy killing'."¹⁹⁶

The boldness and daring which characterizes most of Glanville Williams' book dims perceptibly when he comes to involuntary euthanasia proposals. As to the senile, he states:

At present the problem has certainly not reached the degree of seriousness that would warrant an effort being made to change traditional attitudes toward the sanctity of life of the aged. Only the grimmest necessity could bring about a change that, however cautious in its approach, would probably cause apprehension and deep distress to many people, and inflict a traumatic injury upon the accepted code of behaviour built up by two thousand years of the Christian religion. It may be however, that as the problem becomes more acute it will itself cause a reversal of generally accepted values.¹⁹⁷

To me, this passage is the most startling one in the book. On page 348 Williams invokes "traditional attitudes towards the sanctity of life" and "the accepted code of behaviour built up by two thousand years of the christian religion" to check the extension of euthanasia to the senile, but for 347 pages he had been merrily rolling along debunking both. Substitute "cancer victim" for "the aged" and Williams' passage is essentially the argument of many of his *opponents* on the voluntary euthanasia question.

The unsupported comment that "the problem [of senility] has certainly not reached the degree of seriousness" to warrant euthanasia is also rather puzzling, particularly coming as it does after an observation by Williams on the immediately preceding page that "it is increasingly common for men and women to reach an age of 'second childishness and mere oblivion,' with a loss of almost all adult faculties except that of digestion."¹⁹⁸

How "serious" does a problem have to be to warrant a change in these "traditional attitudes"? If, as the statement seems to indicate, "seriousness" of a problem is to be determined numerically, the problem of the cancer victim does not appear to be as substantial as the problem of the senile.¹⁹⁹ For example, taking just the 95,837

196. *Ibid.*

197. Williams, p. 348.

198. *Id.* at 347.

199. Of all first admissions to New York State Civil Hospitals for mental disorders in 1950, some 5,818 patients—or more than one third—were classified as cerebral arteriosclerosis or senile cases. There were 3,379

first admissions to "public prolonged-care hospitals" for mental diseases in the United States in 1955, 23,561—or one fourth—were cerebral arteriosclerosis or senile brain disease cases.²⁰⁰ I am not at all sure that there are 20,000 cancer victims per year who die *unbearably painful* deaths. Even if there were, I cannot believe that among their ranks are some 20,000 per year who, when still in a rational state, so long for a quick and easy death that they would avail themselves of legal machinery for euthanasia.²⁰¹

If the problem of the incurable cancer victim "has reached the degree of seriousness that would warrant an effort being made to change traditional attitudes toward the sanctity of life," as Williams obviously thinks it has, then so has the problem of senility. In any event, the senility problem will undoubtedly soon reach even Williams requisite degree of seriousness:

A decision concerning the senile may have to be taken within the next twenty years. The number of old people are increasing by leaps and bounds. Pneumonia, 'the old man's friend' is now checked by antibiotics. The effects of hardship, exposure, starvation and accident are now minimized. Where is this leading us? . . . What of the drooling, helpless, disorientated old man or the doubly incontinent old woman lying log-like in bed? Is it here that the real need for euthanasia exists?²⁰²

If, as Williams indicates, "seriousness" of the problem is a major criterion for euthanatizing a category of unfortunates, the sum total of mentally deficient persons would appear to warrant high priority, indeed.²⁰³

psychoses with cerebral arteriosclerosis and 2,439 senile psychoses. In the case of cerebral arteriosclerosis this represented a 600% numerical increase and a 300% increase in the proportion of total first admissions since 1920. The senile psychoses constituted almost a 400% numerical increase and a 155% increase in the proportion of total first admissions since 1920. Malzberg, *A Statistical Review of Mental Disorders in Later Life*, in *Mental Disorders in Later Life* 13 (Kaplan ed. 1956). Dr. George S. Stevenson classes both psychoses together as "mental illness of aging": "As a rule these patients have very limited prospect of recovery. In fact, they die on the average within fifteen months after admission to a mental hospital." Stevenson, *Mental Health Planning For Social Action* 41 (1956).

200. U.S. Dep't of Health, Education and Welfare, *Patients in Mental Institutions 1955*, Part II, Public Hospital for the Mentally Ill 21. Some 13,972 were cerebral arteriosclerosis cases; 9,589 had senile brain diseases.

201. See note 143 *supra*.

202. Banks, *Euthanasia*, 26 Bull. N.Y. Acad. Med. 297, 305 (1950).

203. "Mental diseases are said to be responsible for as much time lost in hospitals as all other diseases combined." Boudreau, *Mental Health: The New Public Health Frontier*, 286 Annals Am. Acad. Pol. & Soc. Sci. 1 (1953). As of about ten years ago, there were "over 900,000 patients under the care and supervision of mental hospitals." Felix and Kramer, *Extent of the Problem of Mental Disorders*, *id.* at 5, 10. Taking only the figures of persons sufficiently ill to warrant admission into a hospital for long-term care of psychiatric disorders, "at the end of 1950 there were 577,000 patients . . . in all long-term mental hospitals." *Id.* at 9. This figure represents 3.8

When Williams turns to the plight of the "hopelessly defective infants," his characteristic vim and vigor are, as in the senility discussion, conspicuously absent:

While the Euthanasia Society of England has never advocated this, the Euthanasia Society of America did include it in its original program. The proposal certainly escapes the chief objection to the similar proposal for senile dementia: it does not create a sense of insecurity in society, because infants cannot, like adults, feel anticipatory dread of being done to death if their condition should worsen. Moreover, the proposal receives some support on eugenic grounds, and more importantly on humanitarian grounds—both on account of the parents, to whom the child will be a burden all their lives, and on account of the handicapped child itself. (It is not, however, proposed that any child should be destroyed against the wishes of its parents.) Finally, the legalization of euthanasia for handicapped children would bring the law into closer relation to its practical administration, because juries do not regard parental mercy-killing as murder. For these various reasons the proposal to legalize humanitarian infanticide is put forward from time to time by individuals. They remain in a very small minority, and the proposal may at present be dismissed as politically insignificant.²⁰⁴

It is understandable for a reformer to limit his present proposals for change to those with a real prospect of success. But it is hardly reassuring for Williams to cite the fact that only "a very small minority" has urged euthanasia for "hopelessly defective infants" as the *only* reason for not pressing for such legislation now. If, as Williams sees it, the only advantage voluntary euthanasia has over the involuntary variety lies in the organized movements on its behalf, that advantage can readily be wiped out.

In any event, I do not think that such "a very small minority" has advocated "humanitarian infanticide." Until the organization of the English and American societies led to a concentration on the voluntary type, and until the by-products of the Nazi euthanasia program somewhat embarrassed, if only temporarily, most proponents of involuntary euthanasia, about as many writers urged one type as another.²⁰⁵ Indeed, some euthanasiasts have taken consider-

per 1,000 population, and a "fourfold increase in number of patients and a twofold increase in ratio of patients to general population since 1903." *Ibid.*

"During 1950, the state, county and city mental hospitals spent \$390,000,000 for care and maintenance of their patients. *Id.* at 13.

204. Williams, pp. 349-50.

205. In Turano, *Murder by Request*, 36 Am. Mercury 423 (1935), the author goes considerably beyond the title of his paper. He scores the "barbarous social policy" which nurtures "infant monstrosities and hopelessly injured children for whom permanent suffering is the sole joy of living" and "old men and women awaiting slow extinction from the accumulated

able pains to demonstrate the superiority of defective infant euthanasia over incurably ill euthanasia.²⁰⁶

ailments of senility," *id.* at 424, and notes in his discussion of "permissive statutes" that "when the sufferer is not mentally competent, the decision could be left to near relatives," *id.* at 428.

In *Should They Live?*, 7 American Scholar 454 (1938) Dr. W. G. Lennox refers to the congenital idiots, the incurably sick, the mentally ill and the aged as "that portion of our population which is a heavy and permanent liability," *id.* at 457, and agrees with others that "there is somewhere a biological limit to altruism, even for man," *id.* at 458. Dr. Lennox would presently eliminate "only the idiots and monsters, the criminal permanently insane and the suffering incurables who themselves wish for death," *id.* at 464. W. W. Gregg similarly advocates euthanasia for all "criminally or hopelessly insane," *The Right to Kill*, 237 No. Am. Rev. 239, 247 (1934) and concludes (*id.* at 249):

With the coming of a more rational social order . . . it is possible to foresee the emergence of a socialized purpose to eliminate such human life as shows itself conspicuously either inhuman, or unhuman, or unable to function happily; in order thereby to help bring about a safer and fuller living for that normal humanity which holds the hope of the future.

W. A. Shumaker, in *Those Unfit to Live*, 29 L.N. 165, 166-67 (1925) comments:

Could we but devise an acceptable formula, ten thousand idiots annually put to death by state boards of health would mean no more to us than ten thousand pedestrians annually put to death by automobilists do now.

* * *

It is impossible to give a common sense reason why an absolute idiot should be permitted to live. His life is of no value to him or to anyone else, and to maintain its existence absorbs a considerable part of the life of a normal being. Of course one shrinks at the thought of putting him to death. But why is it that we shrink? And why, though we shrink from such an act, do we find it possible to excuse him who does it?

* * *

Is the balance swinging too far toward overconsideration not only for the idiot but for the moron and the lunatic and too little consideration for the normality on which civilization must rest?

In 1935, Dr. Alexis Carrel, the Rockefeller Institute's famed Nobel Prize winner, took the position that "not only incurables but kidnapers, murderers, habitual criminals of all kinds, as well as the hopelessly insane, should be quietly and painlessly disposed of." *Newsweek*, Nov. 16, 1935, p. 40; *Time*, Nov. 18, 1935, p. 53; *Pro and Con: Right and Wrong of Mercy Killing*, 1 The Digest 22 (1937).

Another debate on mercy killing, *Pro & Con: Shall We Legalize "Mercy Killing"*, 33 Readers Digest, Nov. 1938, p. 94 similarly embraced involuntary situations. The "question presented" was:

Should physicians have the legal privilege of putting painlessly out of their sufferings *unadjustably defective infants*, patients suffering from painful and incurable illness and the *hopelessly insane and feeble-minded* provided, of course, that maximum legal and professional safeguards against abuse are set up, *including the consent of the patient when rational and adult?* (Emphasis added.)

The proponents of euthanasia made the pitch for voluntary euthanasia, then shifted (p. 95):

Euthanasia would also do away with our present savage insistence that some of us must live on incurably insane or degraded by the helplessness of congenital imbecility.

For the results of a 1937 national poll on the question which covered the problem of "infants born permanently deformed or mentally handicapped" as well as "persons incurably and painfully ill" see note 207 *infra*, and accompanying text.

206. Dr. Foster Kennedy believes euthanasia of congenital idiots has two major advantages over voluntary euthanasia (1) error in diagnosis and

As for dismissing euthanasia of defective infants as "politically insignificant," the only poll that I know of which measured the public response to both types of euthanasia revealed that 45% favored euthanasia for defective infants under certain conditions while only 37.3% approved euthanasia for the incurably and painfully ill under any conditions.²⁰⁷ Furthermore, of those who favored the mercy killing cure for incurable adults, some 40% would require only family permission or medical board approval, but not the patient's permission.²⁰⁸

Nor do I think it irrelevant that while public resistance caused Hitler to yield on the adult euthanasia front, the killing of malformed and idiot children continued unhindered to the end of the war, the definition of "children" expanding all the while.²⁰⁹ Is it the embarrassing experience of the Nazi euthanasia program which has rendered destruction of defective infants presently "politically insignificant"? If so, is it any more of a jump from the incurably and painfully ill to the unorthodox political thinker than it is from the hopelessly defective infant to the same "unsavory character?"

possibility of betterment by unforeseen discoveries are greatly reduced; (2) there is not mind enough to hold any dream or hope which is likely to be crushed by the forthright statement that one is doomed, a necessary communication under a voluntary euthanasia program. Kennedy's views are contained in *Euthanasia: To Be Or Not To Be*, Colliers, May 20, 1939, p. 15, reprinted, with the notation that his views remain unchanged, in Colliers, April 22, 1950, p. 13; *The Problem of Social Control of the Congenital Defective*, 99 Am. J. Psychiatry 13 (1942). See also text at notes 72-74 *supra*.

Dr. Wolbarst also indicates that error in diagnosis and possibilities of a cure are reduced in the case of insane or defective people. See text at notes 74-76, *supra*.

207. *The Fortune Quarterly Survey*: IX, Fortune, July 1937, pp. 96, 106. Actually, a slight majority of those who took a position on the defective infants favored euthanasia under certain circumstances since 45% approved under certain circumstances, 40.5% were unconditionally opposed, and 14.5% were undecided. In the case of the incurably ill, only 37.3% were in favor of euthanasia under any set of safeguards, 47.5% were flatly opposed, and 15.2% took no position.

Every major poll taken in the United States on the question has shown popular opposition to voluntary euthanasia. In 1937 and 1939 the American Institute of Public Opinion polls found 46% in favor, 54% opposed. A 1947 poll by the same group found only 37% in favor, 54% opposed and 9% of no opinion. For a discussion of these and other polls by various newspapers and a breakdown of the public attitude on the question in terms of age, sex, economic and educational levels see Note, *Judicial Determination of Moral Conduct In Citizenship Hearings*, 16 U. of Chi. L. Rev. 138, 141-42 and n. 11 (1948).

As Williams notes, however, at 332, a 1939 British Institute of Public Opinion poll found 68% of the British in favor of some form of legal euthanasia.

208. *The Fortune Quarterly Survey*, note 207, *supra*, at 106.

209. Mitscherlich and Mielke, *Doctors of Infamy* 114 (1949). The Reich Committee for Research on Hereditary Diseases and Constitutional Susceptibility to Severe Diseases" originally dealt only with child patients up to the age of three, but the age limit was later raised to eight, twelve, and apparently even sixteen or seventeen years. *Id.* at 116.

Or is it not so much that the euthanasiasts are troubled by the Nazi experience as it is that they are troubled that the public is troubled by the Nazi experience?

I read Williams' comments on defective infants for the proposition that there are some very good reasons for euthanatizing defective infants, but the time is not yet ripe. When will it be? When will the proposal become politically significant? After a voluntary euthanasia law is on the books and public opinion is sufficiently "educated?"

Williams' reasons for not extending euthanasia—once we legalize it in the narrow "voluntary" area—to the senile and the defective are much less forceful and much less persuasive than his arguments for legalizing voluntary euthanasia in the first place. I regard this as another reason for not legalizing voluntary euthanasia in the first place.

B. The Parade of Horrors.

Look, when the messenger cometh, shut the door, and hold him fast at the door; is not the sound of his master's feet behind him?²¹⁰

This is the "wedge principle," the "parade of horrors" objection, if you will, to voluntary euthanasia. Glanville Williams' peremptory retort is:

This use of the 'wedge' objection evidently involves a particular determination as to the meaning of words, namely the words 'if raised to a general line of conduct.' The author supposes, for the sake of argument, that the merciful extinction of life in a suffering patient is not in itself immoral. Still it is immoral, because if it were permitted this would admit 'a most dangerous wedge that might eventually put all life in a precarious condition.' It seems a sufficient reply to say that this type of reasoning could be used to condemn any act whatever, because there is no human conduct from which evil cannot be imagined to follow if it is persisted in when some of the circumstances are changed. All moral questions involve the drawing of a line, but the 'wedge principle' would make it impossible to draw a line, because the line would have to be pushed farther and farther back until all action became vetoed.²¹¹

I agree with Williams that if a first step is "moral" it is moral wherever a second step may take us. The real point, however, the

210. II *Kings*, VI, 32, quoted and applied in Sperry, *The Case Against Mercy Killing*, 70 *Am. Mercury* 271, 276 (1950).

211. Williams, p. 315. At this point, Williams is quoting from Sullivan, *Catholic Teaching on the Morality of Euthanasia* 54-55 (1949). This thorough exposition of the Catholic Church's position on euthanasia was originally published by the Catholic University of America Press, then republished by the Newman Press as *The Morality of Mercy Killing* (1950).

point that Williams sloughs, is that whether or not the first step is precarious, is perilous, is worth taking, rests in part on what the second step is likely to be.

It is true that the "wedge" objection can always be advanced, the horrors can always be paraded. But it is no less true that on some occasions the objection is much more valid than it is on others. One reason why the "parade of horrors" cannot be too lightly dismissed in this particular instance is that Miss Voluntary Euthanasia is not likely to be going it alone for very long. Many of her admirers, as I have endeavored to show in the preceding section, would be neither surprised nor distressed to see her joined by Miss Euthanatize the Congenital Idiots and Miss Euthanatize the Permanently Insane and Miss Euthanatize the Senile Dementia. And these lasses—whether or not they themselves constitute a "parade of horrors"—certainly make excellent majorettes for such a parade:

Some are proposing what is called euthanasia; at present only a proposal for killing those who are a nuisance to themselves; but soon to be applied to those who are a nuisance to other people.²¹²

Another reason why the "parade of horrors" argument cannot be too lightly dismissed in this particular instance, it seems to me, is that the parade *has* taken place in our time and the order of procession has been headed by the killing of the "incurables" and the "useless":

Even before the Nazis took open charge in Germany, a propaganda barrage was directed against the traditional compassionate nineteenth-century attitudes toward the chronically ill, and for the adoption of a utilitarian, Hegelian point of view. . . . Lay opinion was not neglected in this campaign. Adults were propagandized by motion pictures, one of which, entitled 'I Accuse', deals entirely with euthanasia. This film depicts the life history of a woman suffering from multiple sclerosis; in it her husband, a doctor, finally kills her to the accompaniment of soft piano music rendered by a sympathetic colleague in an adjoining room. Acceptance of this ideology was implanted even in the children. A widely used high-school mathematics text . . . included problems stated in distorted terms of the cost of caring for and rehabilitating the chronically sick and crippled. One of the problems asked, for instance, how many new housing units could be built and how many marriage-allowance loans could be given to newly wedded couples for the amount of money it cost the state to care for 'the crippled, the criminal and the insane. . . .' The beginnings at first were merely a subtle shift in emphasis in the basic attitude of the physicians. *It started with the ac-*

212. Chesterton, *Euthanasia and Murder*, 8 Am. Rev. 486, 490 (1937).

ceptance of the attitude, basic in the euthanasia movement, that there is such a thing as life not worthy to be lived. This attitude in its early stages concerned itself merely with the severely and chronically sick. Gradually the sphere of those to be included in this category was enlarged to encompass the socially unproductive, the ideologically unwanted, the racially unwanted and finally all non-Germans. But it is important to realize that the infinitely small wedged-in lever from which this entire trend of mind received its impetus was the attitude toward the non-rehabilitatable sick.²¹³

213. Alexander, *Medical Science Under Dictatorship*, 241 New England Journal of Medicine 39, 44, 40 (1949) (emphasis added). To the same effect is Ivy, *Nazi War Crimes of a Medical Nature*, 139 J.A.M.A. 131, 132 (1949), concluding that the practice of euthanasia was a factor which led to "mass killing of the aged, the chronically ill, 'useless eaters' and the politically undesirable," and Ivy, *Nazi War Crimes of a Medical Nature*, 33 Federation Bulletin 133, 142 (1947), noting that one of the arguments the Nazis employed to condone their criminal medical experiments was that "if it is right to take the life of useless and incurable persons, which as they point out has been suggested in England and the United States, then it is right to take the lives of persons who are destined to die for political reasons."

Doctors Leo Alexander and A. C. Ivy were both expert medical advisors to the prosecution at the Nuremberg Trials.

See also the November 25, 1940 entry to Shirer, *Berlin Diary* 454, 458-59 (1941):

I have at last got to the bottom of these 'mercy killings'. It's an evil tale. The Gestapo, with the knowledge and approval of the German government, is systematically putting to death the mentally deficient population of the Reich. . . .

X, a German told me yesterday that relatives are rushing to get their kin out of private asylums and out of the clutches of the authorities. He says the Gestapo is doing to death persons who are merely suffering temporary derangement or just plain nervous breakdown.

What is still unclear to me is the motive for these murders. Germans themselves advance three:

* * *

3. That they are simply the result of the extreme Nazis deciding to carry out their eugenic and sociological ideas.

* * *

The third motive seems most likely to me. For years a group of radical Nazi sociologists who were instrumental in putting through the Reich's sterilization laws have pressed for a national policy of eliminating the mentally unfit. They say they have disciples among many sociologists in other lands, and perhaps they have. Paragraph two of the form letter sent the relatives plainly bears the stamp of the sociological thinking: 'In view of the nature of his serious, incurable ailment, his death, which saved him from a lifelong institutional sojourn, is to be regarded merely as a release.'

This contemporaneous report is supported by evidence uncovered at the Nuremberg Medical Trial. Thus, an August, 1940 form letter to the relatives of a deceased mental patient states in part: "Because of her grave mental illness life was a torment for the deceased. You must therefore look on her death as a release." This form letter is reproduced in Mitscherlich and Mielke, *Doctors of Infamy* 103 (1949). Dr. Alexander Mitscherlich and Mr. Fred Mielke attended the trial as delegates chosen by a group of German medical societies and universities.

According to the testimony of the chief defendant at the Nuremberg Medical Trial, Karl Brandt, Reich Commissioner for Health and Sanitation and personal physician to Hitler, the Fuhrer has indicated in 1935 that if

The apparent innocuousness of Germany's "small beginnings" is perhaps best shown by the fact that German Jews were at first excluded from the program. For it was originally conceived that "the blessing of euthanasia should be granted only to [true] Germans."²¹⁴

Relatively early in the German program, Pastor Braune, Chairman of the Executive Committee of the Domestic Welfare Council of the German Protestant Church, called for a halt to euthanasia measures "since they strike sharply at the moral foundations of the nation as a whole. The inviolability of human life is a pillar of any social order."²¹⁵ And the pastor raised the same question which euthanasia opponents ask today, as well they might, considering the disinclination of many in the movement to stop at voluntary "mercy killings": Where do we, how do we, draw the line? The good pastor asked:

How far is the destruction of socially unfit life to go? The mass methods used so far have quite evidently taken in many people who are to a considerable degree of sound mind. . . . Is it intended to strike only at the utterly hopeless cases—the idiots and imbeciles? The instruction sheet, as already mentioned, also lists senile diseases. The latest decree by the same authorities requires that children with serious congenital disease and malformation of every kind be registered, to be collected and processed in special institutions. This necessarily gives rise to grave apprehensions. Will a line be drawn at the tubercular? In the case of persons in custody by court order euthanasia measures have evidently already been initiated. Are other abnormal or anti-social persons likewise to be included? Where is the borderline? Who is abnormal, antisocial, hopelessly sick?²¹⁶

Williams makes no attempt to distinguish or minimize the Nazi Germany experience. Apparently he does not consider it worthy of mention in a euthanasia discussion. There are, however, a couple of obvious arguments by which the Nazi experience can be minimized.

war came he would effectuate the policy of euthanasia since in the general upheaval of war the open resistance to be anticipated on the part of the church would not be the potent force it might otherwise be. Mitscherlich and Mielke *supra* at 91.

Certain petitions to Hitler by parents of malformed children requesting authority for "mercy deaths" seem to have played a part in definitely making up his mind. *Ibid.*

214. Defendant Viktor Brack, Chief Administrative Officer in Hitler's private chancellory, so testified at the Nuremberg Medical Trial, 1 Trials of War Criminals Before the Nuremberg Military Tribunal Under Control Council Law No. 10, 877-80 (1950) ("The Medical Case").

215. Mitscherlich and Mielke, *op. cit. supra* note 213, at 107.

216. *Ibid.* According to testimony at the Nuremberg Medical Trial, although they were told that "only incurable patients, suffering severely, were involved," even the medical consultants to the program were "not quite clear on where the line was to be drawn." *Id.* at 94.

One goes something like this: It is silly to worry about the prospects of a dictatorship utilizing euthanasia "as a pretext for putting inconvenient citizens out of the way. Dictatorships have no occasion for such subterfuges. The firing squad is less bother."²¹⁷ One reason why this counter argument is not too reassuring, however, if again I may be permitted to be so unkind as to meet speculation with a concrete example to the contrary, is that Nazi Germany had considerable occasion to use just such a subterfuge.

Thus, Dr. Leo Alexander observes:

It is rather significant that the German people were considered by their Nazi leaders more ready to accept the exterminations of the sick than those for political reasons. It was for that reason that the first exterminations of the latter group were carried out under the guise of sickness. So-called 'psychiatric experts' were dispatched to survey the inmates of camps with the specific order to pick out members of racial minorities and political offenders from occupied territories and to dispatch them to killing centers with specially made diagnoses such as that of 'inveterate German hater' applied to a number of prisoners who had been active in the Czech underground.

* * *

A large number of those marked for death for political or racial reasons were made available for 'medical experiments involving the use of involuntary human subjects.'²¹⁸

The "hunting season" in Germany officially opened when, Hitler signed on his own letterhead, a secret order dated September 1, 1939, which read:

Reichsleiter Bouhler and Dr. Brandt, M.D., are charged with the responsibility of enlarging the authority of certain physicians, to be designated by name, in such a manner that persons who, according to human judgment, are incurable can, upon a more careful diagnosis of their condition of sickness, be accorded a mercy death.²¹⁹

217. *Pro & Con: Shall We Legalize "Mercy Killing"*, 33 *Readers Digest*, Nov. 1938, p. 94 at 96.

218. Alexander, *supra* note 213, at 41. Dr. Alexander Mitscherlich and Mr. Fred Mielke similarly note:

The granting of 'dying aid' in the case of incurable mental patients and malformed or idiot children may be considered to be still within the legitimate sphere of medical discussion. But as the 'winnowing process' continued, it moved more and more openly as purely political and ideological criteria for death, whether the subjects were considered to be 'undesirable racial groups,' or whether they had merely become incapable of supporting themselves. The camouflage around these murderous intentions is revealed especially by proof that in the concentration camps prisoners were selected by the same medical consultants who were simultaneously sitting in judgment over the destiny of mental institution inmates. Mitscherlich and Mielke, *op. cit. supra* note 213 at 41.

219. This is the translation rendered in the judgment of Military Tribunal 1, 2 Trials of War Criminals Before The Nuremberg Military Tri-

Physicians asked to participate in the program were told that the secrecy of the order was designed to prevent patients from becoming "too agitated" and that it was in keeping with the policy of not publicizing home front measures in time of war.²²⁰

About the same time that aged patients in some hospitals were being given the "mercy" treatment,²²¹ the Gestapo was also "systematically putting to death the mentally deficient population of the Reich."²²²

The courageous and successful refusal by a Protestant pastor to deliver up certain cases from his asylum²²³ well demonstrates that even the most totalitarian governments are not always indifferent to the feelings of the people, that they do not always feel free to resort to the firing squad. Indeed, vigorous protests by other ecclesiastical personalities and some physicians, numerous requests of various public prosecutors for investigation of the circumstances surrounding the mysterious passing away of relatives, and a generally aroused public opinion finally caused Hitler to yield, if only temporarily, and in August of 1941 he verbally ordered the dis-

bunals Under Control Council Law No. 10, 195 (1950) ("The Medical Case"). A slightly different but substantially identical translation appears in Mitscherlich and Mielke, *op. cit. supra* note 213 at 92. The letter, Document 630-PS, Prosecution Exhibit 330, as written in the original German, may be found in 26 Trial of Major War Criminals Before the International Military Tribunal 169 (1947). For conflicting views on whether or not the order was back-dated, compare Mitscherlich and Mielke, *op. cit. supra* with Koessler, *Euthanasia In The Hadamar Sanatorium and International Law*, 43 J. Crim. L., C. & P.S. 735, 737 (1953).

220. Mitscherlich and Mielke, *op. cit. supra* note 213, at 93-94.

221. In the fall of 1940, Catholic priests at a large hospital near Urach "notices that elderly people in the hospital were dying in increasing numbers, and dying on certain days." Straight, *Germany Executes Her "Unfit"*, 104 New Republic 627 (1941). Such incidents led a German bishop to ask the Supreme Sacred Congregation whether it is right to kill those "who, although they have committed no crime deserving death, yet, because of mental or physical defects, are no longer able to benefit the nation, and are considered rather to burden the nation and to obstruct its energy and strength." *Ibid.* The answer was, of course, in the negative, *ibid.*, but "it is doubtful if the mass of German Catholics, even if they learned of this statement from Rome, which is improbable, understood what it referred to. Only a minority in Germany knew of the 'mercy deaths'." Shirer, *op. cit. supra* note 213, at 459 n. 1.

222. Shirer, *op. cit. supra* note 213, at 454.

223. "Late last summer, it seems Pastor von Bodelschwingh was asked to deliver up certain of his worst cases to the authorities. Apparently he got wind of what was in store for them. He refused. The authorities insisted. Pastor von Bodelschwingh hurried to Berlin to protest.

Pastor von Bodelschwingh returned to Bethel. The local Gauleiter ordered him to turn over some of his inmates. Again he refused. Berlin then ordered his arrest. This time the Gauleiter protested. The pastor was the most popular man in his province. To arrest him in the middle of war would stir up a whole world of unnecessary trouble. He himself declined to arrest the man. Let the Gestapo take the responsibility; he wouldn't. This was just before the night of September 18, [1940]. The bombing of the Bethel asylum followed. Now I understand why a few people wondered as to who dropped the bombs." Shirer, *op. cit. supra* note 213 at 454-55.

continuance of the adult euthanasia program. Special gas chambers in Hadamar and other institutions were dismantled and shipped to the East for much more extensive use of Polish Jews.²²⁴

Perhaps it should be noted, too, that even dictatorships fall prey to the inertia of big government:

It is . . . interesting that there was so much talk against euthanasia in certain areas of Germany, particularly in the region of Wiesbaden, that Hitler in 1943 asked Himmler to stop it. But, it had gained so much impetus by 1943 and was such an easy way in crowded concentration camps to get rid of undesirables and make room for newcomers, that it could not be stopped. The wind had become a whirlwind.²²⁵

Another obvious argument is that it just can't happen here. I hope not. I think not.

But then, neither did I think that tens of thousands of perfectly loyal native-born Americans would be herded into prison camps without proffer of charges and held there for many months, even years, because they were of "Japanese blood"²²⁶ and, although the

224. Mitscherlich and Mielke, *op. cit. supra* note 213, at 113-114; Koessler, *supra* note 219, at 739.

225. Ivy, *Nazi War Crimes of a Medical Nature*, 33 *Federation Bulletin* 133, 134 (1947).

226. As Justice Murphy pointed out in his dissenting opinion in *Korematsu v. United States*, 323 U.S. 214, 241-42 (1944):

No adequate reason is given for the failure to treat these Japanese Americans on an individual basis by holding investigations and hearings to separate the loyal from the disloyal, as was done in the case of persons of German and Italian ancestry. It is asserted merely that the loyalties of this group 'were unknown and time was of the essence.' Yet nearly four months elapsed after Pearl Harbor before the first exclusion order was issued; nearly eight months went by until the last order was issued; and the last of these 'subversive' persons was not actually removed until almost eleven months had elapsed. Leisure and deliberation seem to have been more of the essence than speed. And the fact that conditions were not such as to warrant a declaration of martial law adds strength to the belief that the factors of time and military necessity were not as urgent as they have been represented to be.

Moreover, there was no adequate proof that the Federal Bureau of Investigation and the military and naval intelligence services did not have the espionage and sabotage situation well in hand during this long period. Nor is there any denial of the fact that not one person of Japanese ancestry was accused or convicted of espionage or sabotage after Pearl Harbor while they were still free, a fact which is some evidence of the loyalty of the vast majority of these individuals and of the effectiveness of the established methods of combatting these evils. It seems incredible that under these circumstances it would have been impossible to hold loyalty hearings for the mere 112,000 persons involved—or at least for the 70,000 American citizens—especially when a large part of this number represented children and elderly men and women.

Justice Murphy then went on to note that shortly after the outbreak of World War II the British Government examined over 70,000 German and Austrian aliens and in six months freed 64,000 from internment and from any special restrictions. 354 U.S. 242 n. 16.

See generally Rostow, *The Japanese American Cases—A Disaster*, 54 *Yale L.J.* 489 (1945), a tale well calculated to keep you in anger and shame.

general who required these measures emitted considerable ignorance and bigotry,²²⁷ his so-called military judgment would be largely sustained by the highest court of the land. The Japanese American experience of World War II undoubtedly fell somewhat short of first-class Nazi tactics, but we were getting warm. I venture to say it would not be too difficult to find American citizens of Japanese descent who would maintain we were getting very warm indeed.

In this regard, some of Justice Jackson's observations in his *Korematsu* dissent²²⁸ seem quite pertinent:

All who observe the work of courts are familiar with what Judge Cardozo described as 'the tendency of a principle to expand itself to the limit of its logic.' [Nature of the Judicial Process, p. 51.] A military commander may overstep the bounds of constitutionality, and it is an incident. But if we review and approve, that passing incident becomes the doctrine of the Constitution. There it has a generative power of its own, and all that it creates will be in its own image. Nothing better illustrates this danger than does the Court's opinion in this case.

It argues that we are bound to uphold the conviction of Korematsu because we upheld one in *Hirabayashi v. United States*, 320 U.S. 81, when we sustained these orders in so far as they applied a curfew requirement to a citizen of Japanese ancestry. I think we should learn something from that experience.

In that case we were urged to consider only the curfew feature, that being all that technically was involved, because it was the only count necessary to sustain Hirabayashi's conviction and sentence. We yielded, and the Chief Justice guarded the opinion as carefully as language will do. . . . However, in spite of our

227. See, e.g., General J. L. Dewitt's Final Recommendation to the Secretary of War, *U.S. Army, Western Defense Command, Final Report, Japanese Evacuation From the West Coast, 1942* (1943) at 32 ("The Japanese race is an enemy race and while many second and third generation Japanese born on United States soil, possessed of United States citizenship, have become 'Americanized,' the racial strains are undiluted. . . ."), and his subsequent testimony, *Hearings Before Subcommittee of House Committee on Naval Affairs on H.R. 30, 78th Cong., 1st Sess.* (1943) at 739-40 ("You needn't worry about the Italians at all except in certain cases. Also, the same for the Germans except in individual cases. But we must worry about the Japanese all the time until he is wiped off the map. Sabotage and espionage will make problems as long as he is allowed in this area—problems which I don't want to have to worry about.") After a careful study, Professor (now Dean) Rostow took this position:

The dominant factor in the development of this policy was not a military estimate of a military problem, but familiar West Coast attitudes of race prejudice. The program of excluding all persons of Japanese ancestry from the coastal area was conceived and put through by the organized minority whose business it has been for forty-five years to increase and exploit racial tensions on the West Coast. The Native Sons and Daughters of the Golden West and their sympathizers, were lucky in their general, for General DeWitt amply proved himself to be one of them in opinion and values.

Rostow, *supra* note 226, at 496.

228. See note 226, *supra*.

limiting words we did validate a discrimination on the basis of ancestry for mild and temporary deprivation of liberty. Now the principle of racial discrimination is pushed from support of mild measures to very harsh ones, and from temporary deprivations to indeterminate ones. And the precedent which it is said requires us to do so is *Hirabayashi*. The Court is now saying that in *Hirabayashi* we did decide the very things we there said we were not deciding. Because we said that these citizens could be made to stay in their homes during the hours of dark, it is said we must require them to leave home entirely; and if that, we are told they may also be taken into custody for deportation; and if that, it is argued they may also be held for some undetermined time in detention camps. How far the principle of this case would be extended before plausible reasons would play out, I do not know.²²⁹

It can't happen here. Well, maybe it cannot, but no small part of our Constitution and no small number of our Supreme Court opinions stem from the fear that *it can happen here unless we darn well make sure that it does not* by adamantly holding the line, by swiftly snuffing out what are or might be small beginnings of what we do not want to happen here. To flick off, as Professor Williams does, the fears about legalized euthanasia as so much nonsense, as a chimerical "parade of horrors," is to sweep away much of the ground on which all our civil liberties rest.

Boyd,²³⁰ the landmark search and seizure case which paved the way for the federal rule of exclusion,²³¹ a doctrine which now prevails in over twenty state courts as well,²³² set the mood of our day in treating those accused of crime:

It may be that it is the obnoxious thing in its mildest and least repulsive form; but illegitimate and unconstitutional practices get their first footing in that way, namely, by silent approaches and slight deviations from legal modes of procedure. . . . It is the duty of courts to be watchful for the constitutional rights of the citizen, and against any stealthy encroachments thereon. Their motto should be *obsta principiis*. . . .²³³

229. 323 U.S. at 246-47.

230. *Boyd v. United States*, 116 U.S. 616 (1886).

231. See e.g., *Weeks v. United States*, 232 U.S. 283 (1914); *Gouled v. United States*, 255 U.S. 298 (1921); *McDonald v. United States*, 335 U.S. 451 (1948); *United States v. Jeffers*, 342 U.S. 48 (1951).

232. See *Anno.*, 50 A.L.R. 2d 531, 536, 556-560 (1956).

233. 116 U.S. 616, 635. The search and seizure cases contain about as good an articulation of the "wedge principle" as one can find anywhere, except, perhaps if one turns to the recent *Covert* and *Krueger* cases, where Mr. Justice Black quotes the *Boyd* statement with approval and applies it with vigor:

It is urged that the expansion of military jurisdiction over civilians claimed here is only slight, and that the practical necessity for it is very great. The attitude appears to be that a slight encroachment on the Bill

Recent years have seen the Supreme Court sharply divided on search and seizure questions. The differences, however, have been over *application*, not over the *Boyd-Weeks* "wedge principle"; not over the view, as the great Learned Hand, hardly the frightened spinster type, put it in an oft-quoted phrase, "that what seems fair enough against a squalid huckster of bad liquor may take on a very different face, if used by a government determined to suppress political opposition under the guise of sedition."²³⁴ And when the dissenters have felt compelled to reiterate the reasons for the principle, lest its force be diminished by the failure to apply it in the particular case, and they have groped for the most powerful arguments in its behalf, where have they turned, what have they done? Why, they have employed the very arguments Glanville Williams dismisses so contemptuously. They have cited the Nazi experience. They have talked of the police state, the Knock at the Door, the suppression of political opposition under the guise of sedition. They have trotted out, if you will, the "parade of horrors."²³⁵

of Rights and other safeguards in the Constitution need cause little concern. But to hold that these wives could be tried by the military would be a tempting precedent. Slight encroachments create new boundaries from which legions of power can seek new territory to capture.

Reid v. Covert, 354 U.S. 1, 39-40 (1957).

234. United States v. Kirschenblatt, 16 F.2d 202, 203 (2d cir. 1926).

235. Thus, in *Brinegar v. United States*, 338 U.S. 160 (1949), it was Jackson the Chief Counsel of the United States at the Nuremberg Trials as well as Jackson the Supreme Court Justice who warned (338 U.S. at 180-81): Among deprivations of rights, none is so effective in cowing a population, crushing the spirit of the individual and putting terror in every heart. Uncontrolled search and seizure is one of the first and most effective weapons in the arsenal of every arbitrary government. And one need only briefly to have dwelt and worked among a people possessed of many admirable qualities but deprived of these rights to know that the human personality deteriorates and dignity and self-reliance disappear where homes, persons and possessions are subject at any hour to unheralded search and seizure by the police.

In *United States v. Rabinowitz*, 339 U.S. 56, 82 (1950), Justice Frankfurter cautioned:

By the Bill of Rights the founders of this country subordinated police action to legal restraints, not in order to convenience the guilty but to protect the innocent. Nor did they provide that only the innocent may appeal to these safeguards. They know too well that the successful prosecution of the guilty does not require jeopardy to the innocent. The knock at the door under the guise of a warrant of arrest for a venial or spurious offense was not unknown to them. . . . We have had grim reminders in our day of their experience. Arrest under a warrant for a minor or a trumped-up charge has been familiar practice in the past, is a commonplace in the police state of today, and too well known in this country. . . . The progress is too easy from police action unscrutinized by judicial authorization to the police state.

In *Harris v. United States*, 331 U.S. 145 (1947), four Justices dissented in three separate opinions. The first dissent asked (331 U.S. at 163):

How can there be freedom of thought or freedom of speech or freedom of religion, if the police can, without warrant, search your house and mine from garret to cellar merely because they are executing a warrant

The lengths to which the Court will go in applying the "wedge principle" in the First Amendment area is well demonstrated by instances where those who have labeled Jews "slimy scum" and likened them to "bedbugs" and "snakes"²³⁶ or who have denounced them "as all the garbage that . . . should have been burnt in the incinerators"²³⁷ have been sheltered by the Court so that freedom of speech and religion would not be impaired. Perhaps the supreme example is the *Barnette* case.²³⁸

There, in striking down the compulsory flag salute and pledge, Justice Jackson took the position that "those who begin coercive elimination of dissent soon find themselves exterminating dissenters. Compulsory unification of opinion achieves only the unanimity of the graveyard."²³⁹ "The First Amendment," he pointed out, "was de-

of arrest? How can men feel free if all their papers may be searched, as an incident to the arrest of someone in the house, on the chance that something may turn up, or rather be turned up? Yesterday the justifying document was an illicit ration book, tomorrow it may be some suspect piece of literature.

The second dissent voiced fears of "full impact of today's decision" (331 U.S. at 194):

The principle established by the Court today can be used as easily by some future government determined to suppress political opposition under the guise of sedition as it can be used by a government determined to undo forgers and defrauders. . . . [It] takes no stretch of the imagination to picture law enforcement officers arresting those accused of believing, writing or speaking that which is proscribed, accompanied by a thorough ransacking of their homes as an 'incident' to the arrest in an effort to uncover 'anything' of a seditious nature.

The third dissent pointed out (331 U.S. at 198):

In view of the readiness of zealots to ride roughshod over claims of privacy for any ends that impress them as socially desirable, we should not make inroads on the rights protected by this Amendment.

236. *Terminello v. Chicago*, 337 U.S. 1 (1949), striking down an ordinance which imposed a fine of not more than two hundred dollars for a "breach of peace," defined by the trial court as misbehavior which "stirs the public to anger, invites dispute, brings about a condition of unrest, or creates a disturbance, or if it molests the inhabitants in the enjoyment of peace and quiet by arousing alarm." (337 U.S. at 3.) The Court ruled, per Douglas, J., that a conviction on *any* of the grounds charged could not stand. "There is no room under our Constitution for a more restrictive view. For the alternative would lead to standardization of ideas either by legislatures, courts, or dominant political or community groups" 337 U.S. at 4-5. The dissenting opinion by Jackson, 337 U.S. 13-21, culls long passages from the speech in question.

237. *Kunz v. New York*, 340 U.S. 290 (1951), overturning a conviction and ten dollar fine for holding a religious meeting without a permit, defendant's permit having been revoked after a hearing by the police commissioner on evidence that he had ridiculed and denounced other religious beliefs at prior meetings. Samples of Kunz's prior preachings may be found in Jackson's dissenting opinion, 340 U.S. at 296. Kunz displayed a certain flair for bipartisanship; he also denounced Catholicism as "a religion of the devil" and the Pope as "The anti-Christ". *Ibid.*

238. *Board of Education v. Barnette*, 319 U.S. 624 (1943).

239. 319 U.S. at 641. There was no majority opinion. Chief Justice Stone and Justice Rutledge concurred in Justice Jackson's opinion; Justices Black and Douglas wrote a concurring opinion; and Justice Murphy wrote a separate concurring opinion.

signed to avoid these ends by avoiding these beginnings."²⁴⁰ Justices Black and Douglas kept in step in their concurring opinion by advancing the view that "the ceremonial, when enforced against conscientious objectors . . . is a handy implement for disguised religious persecution."²⁴¹

What were these pernicious "beginnings" again? What was this danger-laden ceremonial again? Why, requiring public school pupils "to participate in the salute honoring the Nation represented by the Flag."²⁴² Talk about "parades of horror"! This one is an extravaganza against which anything euthanasia opponents can muster is drab and shabby by comparison. After all, whatever else Williams and his allies make "mercy-killings" out to be, *these* beginnings are not "patriotic ceremonies."

The point need not be labored. If the prospects of the police state, the knock on Everyman's door, and wide-spread political persecution are legitimate considerations when we enter "opium smoking dens,"²⁴³ when we deal with "not very nice people" and "sordid little cases"²⁴⁴ then why should the prospects of the police state and the systematic extermination of certain political or racial minorities be taken any less seriously when we enter the sickroom or the mental institution, when we deal with not very healthy or not very useful people, when we discuss "euthanasia" under whatever trade name?

If freeing some rapist or murderer is not too great a price to pay for the "sanctity of the home", then why is allowing some cancer victim to suffer a little longer too great a price to pay for the "sanctity of life"? If the sheltering of purveyors of "hateful and hate-stirring attacks on races and faiths"²⁴⁵ may be justified in the name of a transcendent principle, then why may not postponing the death of the suffering "incurable" be similarly justified?

A FINAL REFLECTION

There have been and there will continue to be compelling circumstances when a doctor or relative or friend will violate The Law On The Books and, more often than not, receive protection

240. *Ibid.*

241. 319 U.S. at 644.

242. 319 U.S. at 626.

243. See, e.g., *Johnson v. United States*, 333 U.S. 10 (1948). The point is made in rather homey fashion in Houts, *From Gun to Gavel: The Courtroom Recollections of James Mathers of Oklahoma* 213-17 (1954).

244. The phrases are those of Mr. Justice Frankfurter, dissenting in *United States v. Rabinowitz*, 339 U.S. 56, 68-69 (1950).

245. The phrase is Justice Jackson's dissenting in *Kunz v. New York*, 340 U.S. 290, 295 (1951).

from *The Law In Action*. But this is not to deny that there are other occasions when *The Law On The Books* operates to stay the hand of all concerned, among them situations where the patient is in fact (1) presently incurable, (2) beyond the aid of any respite which may come along in his life expectancy, suffering (3) intolerable and (4) unmitigable pain and of a (5) fixed and (6) rational desire to die. That any euthanasia program may only be the opening wedge for far more objectionable practices, and that even within the bounds of a "voluntary" plan such as Williams' the incidence of mistake or abuse is likely to be substantial, are not much solace to one in the above plight.

It may be conceded that in a narrow sense it is an "evil" for such a patient to have to continue to suffer—if only for a little while. But in a narrow sense, long-term sentences and capital punishment are "evils," too.²⁴⁶ If we can justify the infliction of imprisonment and death by the state "on the ground of the social interests to be protected"²⁴⁷ then surely we can similarly justify the postponement of death by the state. The objection that the individual is thereby treated not as an "end" in himself but only as a "means" to further the common good was, I think, aptly disposed of by Holmes long ago. "If a man lives in society, he is likely to find himself so treated."²⁴⁸

246. Perhaps this would not be true if the only purpose of punishment was to reform the criminal. But whatever *ought to be* the case, this obviously *is not*. "If it were, every prisoner should be released as soon as it appears clear that he will never repeat his offence, and if he is incurable he should not be punished at all." Holmes, *The Common Law* 42 (1881).

247. Michael and Adler, *Crime, Law and Social Science* 351 (1933). The authors continue (at 352):

The end of the criminal law must be the common good, the welfare of a political society determined, of course, by reference to its constitution. Punishment can be justified only as an intermediate means to the ends of deterrence and reformation which, in turn, are means for increasing and preserving the welfare of society. . . .

248. Holmes, *The Common Law* 44 (1881).